COMMUNITY IMCI

Reaching Communities for Child Health and Nutrition:
A Framework for Household and Community IMCI

By Peter Winch, Karen LeBan, Barmak Kusha and Participants at the Workshop "Reaching Communities for Child Health: Advancing PVO/NGO Technical Capacity and Leadership for Household and Community Integrated Management of Childhood Illness (HH/C IMCI)" Baltimore, Maryland, January 17-19, 2001

THE CHILD SURVIVAL TECHNICAL SUPPORT PROJECT

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Overview of the Framework for Household and Community IMCI

The purpose of this report is to clarify the current thinking on the Household and Community component of IMCI (Integrated Management of Childhood Illness). This section presents a brief overview of the Framework for Household and Community IMCI that is described in greater detail throughout this report.

The Integrated Management of Childhood Illness (IMCI) strategy combines improved case management of childhood illness in first-level health facilities with aspects of nutrition, immunization, disease prevention, and promotion of growth and development. There are three components to IMCI, and interventions in all three components encompass both curative and disease preventive/health promotive activities:

1) Improving the skills of health workers;
2) Improving the health system; and
3) Improving household and community practices.

The third component, Household and Community IMCI or HH/C IMCI, was officially launched as an essential component of the IMCI strategy at the First IMCI Global Review and Coordination Meeting in September 1997 (*2*). Meeting participants recognized that improving the quality of care at health facilities alone would not be effective in realizing significant reductions in childhood mortality and morbidity because numerous caretakers currently do not seek care at facilities. Since that first meeting, several efforts were undertaken to strengthen inter-agency collaboration for promoting and implementing community approaches to child health and nutrition.

Sixteen Key Family Practices

At the UNICEF-led International Meeting on Health and Nutrition in Communities held in Durban, South Africa (20-23 June 2000), participants reached consensus on sixteen key family care practices listed in Table 7 on page 54, which are based on scientific evidence and country experience, that contribute to a child's survival and healthy growth (*3*). The key family practices, the backbone of the Household and Community IMCI strategy, are grouped according to practices that:

- promote physical growth and mental development
- prevent disease
- facilitate appropriate home care
- facilitate care seeking behaviors.

The HH/C IMCI Implementation Framework

At the workshop "Reaching Communities for Child Health: Advancing PVO Technical Capacity and Leadership in Household and Community IMCI" held in Baltimore, Maryland (January 17-19, 2001) (*1*), organized by CORE and BASICS II with support from USAID/G, USAID/BHR/PVC, and CSTS, participants endorsed the following operational framework for HH/C IMCI implementation:

"HH/C IMCI is the optimization of a multi-sectoral platform for child health and nutrition that includes three linked requisite elements:

- **Element 1**: Partnerships between health facilities or services and the communities they serve.
- **Element 2**: Appropriate and accessible care and information from community-based providers.
- **Element 3**: Integrated promotion of key family practices critical for child health and nutrition."

This framework enables implementers and their colleagues to better communicate and plan public, private sector, and household interventions that can improve child well-being and reduce child mortality and morbidity in communities within the overall guidelines of the HH/C IMCI strategy established by UNICEF and its partner organizations. The three programmatic Elements are means to work within communities to improve health, nutrition and development outcomes for children and their families.

The multi-sectoral platform, including partnerships with other key ministries (e.g. Agriculture, Water and Sanitation, Local Government) and other key district / community projects and activities (e.g. income generation, civil society organizations), facilitates a multi-pronged approach to the promotion of the Key Family Practices. It is an acknowledgement of the social, political, environmental, and economic context in which families and communities operate.

Principles of the HH/C IMCI Operational Framework

Participants at the CORE Workshop developed the following principles for implementation of HH/C IMCI after much discussion about how HH/C IMCI differs from previous child health and nutrition initiatives.

- HH/C IMCI can be implemented at a national, district, and/or community levels, as appropriate.
- HH/C IMCI can be implemented by multiple actors or by a single organization.
- HH/C IMCI recognizes the importance of curative and preventive interventions in the community for reducing child mortality and morbidity.
- HH/C IMCI can be implemented with or without IMCI Components 1(Health Worker Skills) and 2 (Health System Supports).

- All 3 elements are requisite for (integral parts of) HH/C IMCI.
- Phased introduction of promotion of key family practices is acceptable.
- Phased introduction of the three elements is acceptable.

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Acronyms

ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival (Project)
BCC	Behavior Change Communication
BHR/PVC	Bureau of Humanitarian Response, Office of Private Voluntary Cooperation (USAID)
CB-IMCI	Community-Based IMCI
CDD	Control of Diarrhoeal Diseases
CHW	Community Health Worker
C-IMCI	Community IMCI
CLAS	Comités Locales de Salud (Local Health Committees – Peru)
CORE Group	Child Survival Collaboration and Resources Group
CSTS	Child Survival Technical Support Project (ORC Macro)
ECD	Early Childhood Development
EDP	Essential Drugs Program
HH/C IMCI	Household and Community IMCI
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
IAWG	Inter-Agency Working Group
IMCI	Integrated Management of Childhood Illnesses
KPC	Knowledge, Practices and Coverage (household survey)
MADS	Malaria Awareness Days
MICS	Multiple Indicator Cluster Survey
MIHV	Minnesota International Health Volunteers
MOH	Ministry of Health
MSP	Multi-Sectoral Platform
NGO	Non Governmental Organization
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PD	Positive Deviance
PHC	Primary Health Care
PLA	Participatory Learning and Action
PRA	Participatory Rapid Appraisal / Participatory Rural Appraisal
PVO	Private Voluntary Organization
RRA	Rapid Rural Appraisal
SOTA	State-of-the-Art
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
WHO	World Health Organization

Reaching Communities for Child Health and Nutrition:
A Framework for Household and Community IMCI

Foreword

This is one of a series of State-of-the-Art (SOTA) Technical Reports being prepared on current topics in child survival through the Child Survival Technical Support Project (CSTS) in collaboration with the CORE Group and other partners. These papers attempt to summarize recent trends in research and program implementation and discuss their implications for managers of child survival programs. This report describes a framework for the implementation of the Household and Community component of Integrated Management of Childhood Illness (IMCI), or HH/C IMCI.

We feel the framework described in this report represents an important advance in clarifying what HH/C IMCI consists of in operational terms, and in articulating PVO and NGO approaches to child health and nutrition programs. This report should be viewed as one further step in a continuing dialog about how best to advance the health and nutrition of children at the household and community levels, rather than an authoritative set of guidelines about how to implement programs in the field.

The CORE Group endorses this document as an important next step in strengthening PVO efforts in HH/C IMCI and will use this framework to guide future planning efforts in IMCI.

Acknowledgments

Many individuals contributed to this report, providing input both to earlier drafts of the report, and to the framework when it was presented during and after the CORE Group workshop in January 2001. Among the many people who provided us with significant input several times were Larry Casazza and Alfonso Rosales of the CORE IMCI Working Group; Lynette Walker of the CORE Group, Chris Bessenecker of Project Concern International; Kate Jones, Ann Hirschey, and Della Dash of the United States Agency for International Development, Office of Private Voluntary Cooperation; Leo Ryan, Michel Pacqué, Sandra Bertoli and Rikki Welch of the Child Survival Technical Support Project (CSTS); Eric Starbuck of Save the Children; René Salgado of JSI; Paul Ickx of BASICS II and C. Abeja Apunyo of BASICS II/Uganda; Michael Favin of the CHANGE Project/AED; Niki Abrishamian and Vincent Orinda of UNICEF/New York; Banda Ndiaye of World Vision/South Africa and Robert Pond of USAID/Ghana. The staff of the BASICS II Project were key partners throughout the development of this report, and provided valuable feedback at many points in time.

I Introduction

I.1 Purpose of This Report

This report attempts to clarify current thinking on the Household and Community component of IMCI (Integrated Management of Childhood Illness) (HH/C IMCI). Chapter III provides a general introduction to the IMCI approach, including its history and its three components. The remainder of the report focuses on the third component of IMCI, Improving Household and Community Practices. An implementation framework consisting of three programmatic "Elements" is introduced on Chapter IV. The Elements describe the necessary technical content of a HH/C IMCI program, and the multi-sectoral platform which supports the implementation of the three Elements. Chapters V to VIII cover the technical content of each of the three Elements and the platform in more detail. The Elements and platform are illustrated through the experiences of US-based non-governmental organizations (NGOs), known as private voluntary organizations (PVOs).

Chapter IX discusses linkages between the framework and other health programs such as Roll Back Malaria and Early Childhood Development. Chapter X discusses in detail the principles underlying the framework that were agreed to at the CORE workshop in January 2001. Chapters XI and XII discuss the role of community mobilization in the implementation of HH/C IMCI and leadership roles that NGOs can play in implementation and scaling up. Finally Chapter XIII presents a listing of tools and contact information.

This report differs from many others in that it is not a technical update summarizing key findings from recent research for those who are implementing child health programs in the field. Rather, the report attempts to synthesize and reflect back the experience of NGOs to the NGOs[1] themselves, in order to provide a framework for discussion of integrated approaches to child health and nutrition and suggest further actions that might be taken to further develop these approaches.

While NGOs clearly have much to offer in terms of experiences with community approaches to child health and nutrition, the sharing of these experiences with other partners has at times been hampered by uncertainty about what exactly is meant by Household and Community IMCI, and by the tremendous diversity of NGO activities in the field. It is hoped that the framework as it is discussed here can be used as a tool to help NGOs organize and present lessons learned based on their child survival and HH/C IMCI programs, both to each other and to other public health agencies.

NGOs have proven experience in reducing mortality and morbidity and in improving child health and nutrition at the community level, although the task facing the public health community is huge: more than 11 million children still die before they reach the age of five. In order to reach these children more effectively, those working in the public health arena need to find answers to key questions such as:

- How can improvements to child health services be extended to the household level by

[1] Though this paper is being distributed in the first instance to US-based Private Voluntary Organizations (PVOs), it is our hope that they will share the paper with their local partners (public and private) in the field. Hereafter, PVOs will mostly be referred to by the more common term–NGO (non-governmental organizations).

district level staff?
- How can the scope of existing child survival programs be expanded to include all of the interventions with a proven impact of child mortality and morbidity?
- How can existing child survival programs be scaled up to the district level and beyond the district level so that millions of children benefit from them?
- How can existing child survival programs be maintained in the face of economic and political uncertainty?

Household and Community IMCI presents a platform from which NGOs might assess their programs and work with partners to reach more children more effectively. The framework presented here represents one tool to help with this assessment.

I.2 Household and Community IMCI: A Brief History

The Household and Community component of IMCI (Integrated Management of Childhood Illness) was officially launched as an essential component of the IMCI strategy at the First IMCI Global Review and Coordination Meeting in September 1997 (*2, 4*).[2] Meeting participants recognized that improving the quality of care at health facilities alone would not be effective in realizing significant reductions in childhood mortality and morbidity because numerous caretakers currently do not seek care at facilities. Since that first meeting, many activities have been undertaken by multilateral institutions (UNICEF, WHO, PAHO, the World Bank), the Interagency Working Group (IAWG) on Household and Community IMCI, bilateral agencies (such as USAID) and their contractors, PVOs, Egos, and the CORE Group to strengthen inter-agency collaboration for promoting and implementing community approaches to child health and nutrition.

Since the First IMCI Global Review and Coordination Meeting in September 1997, several terms have been used in WHO and UNICEF documents to represent IMCI-related activities that are implemented at the household and community levels:

- "Community IMCI" (CIMCI) is arguably the most widely recognized term;
- "Household and Community IMCI" (HH/C IMCI) is the term used by the Inter-Agency Working Group on Household and Community Integrated Management of Childhood Illness, a group created after the IMCI global review and consultation in September 1997 that includes representatives of UNICEF, WHO, PAHO, the World Bank, USAID, the BASICS II Project, the CORE Group and several NGOs;
- "Improving Child Care at Family and Community Levels" (*4*) and "Improving Family and Community Practices in Support of Child Health and Development" (found at http://www.who.int/chd/publications/imci/comm.htm) have been used in some WHO documents;
- "Integrated Approaches to Child Health" or "Integrated Approaches to Child Health and Nutrition" have been used both in some WHO documents (*5*) and by the BASICS II Project to refer either to all child health and nutrition activities, or specifically to those activities at the household and community levels; and

[2] Numbers in parentheses refer to articles and documents in the reference list at the end of this report.

- "Improving Child Health and Nutrition in Communities" and "Integrated Community Approaches to Improve the Survival, Health, and Nutrition of All Children" were used at the recent conference in Durban, South Africa held June 20-23, 2000 (*3*).

One of the reasons that these alternatives have been proposed has been the feeling that "Community IMCI" does not adequately represent the broad spectrum of actions that needs to be taken to improve child health. These actions range from advocacy for child health at the national and international levels, to implementation of interventions in households and communities. Another concern has been that the term "IMCI" places the focus on sick children and their illnesses. It has been argued that it is more effective to shift the focus to "wellness" or "health" when working with communities. This report will employ the term Household and Community IMCI (or HH/C IMCI).

While there is not yet consensus on terminology, there has been a general agreement at various meetings on the need to document and disseminate experiences with implementation and evaluation of interventions to improve child health and nutrition at the household and community levels. One of these was The International Workshop on Improving Children's Health and Nutrition in Communities held in Durban, South Africa from June 20-23, 2000, and attended by over 100 delegates from 28 countries (*3*). This meeting reviewed experiences with the promotion of integrated community approaches to improving child health and nutrition. The concluding statement of the Durban meeting stressed the need for collaboration between a wide range of partners in the promotion of a core set of practices to improve child health and nutrition at the household and community levels. Non-governmental organizations, including U.S.-based PVOs, were specifically called upon "to identify and implement effective community and household approaches" to child health and nutrition.

NGOs have a long experience with the development and implementation of these approaches. Much of this experience has been gained through more than 15 years of child survival grants to PVOs funded by the Bureau of Humanitarian Response, Office of Private Voluntary Cooperation of the US Agency for International Development. These grants have built the capacity of PVOs, in collaboration with local Ministry of Health teams and local Egos, to plan, implement and evaluate child survival interventions at both the district and national levels.

In recent meetings, participants have steered away from seeing Household and Community IMCI in terms of a defined set of standard intervention activities. Rather, they have developed a vision of HH/C IMCI as a consensus-building process that focuses on improvements in child health and nutrition at the district level among the different partners involved in any given country. While there is consensus regarding the main outcomes desired, such as decreased mortality and improved nutrition in children, participants at these meetings have recognized various areas of need. The first is a need for models for delivering interventions. Planners also need a broad range of partners with distinct roles, including advocacy, mobilization of resources and program implementation. Multiple entry points are also necessary for initiating work with communities.

I.3 Methodology

Writing this report has been an iterative process, passing through several revisions. Recent articles on IMCI were reviewed (*4, 6-23*), as well as reports from various international meetings where Community IMCI has been discussed, including:

- The First Global Review and Coordination Meeting on Integrated Management of Childhood Illness (IMCI), Santo Domingo, Dominican Republic, 9-12 September 1997 (*2*);
- Reaching Communities for Child Health: Partnering with PVOs in Integrated Management of Child Illness, workshop held at The Pan American Health Organization, Washington, D.C., 24-26 February 1999 (*24*); and
- The International Workshop on Improving Children's Health and Nutrition in Communities, Durban, South Africa, 20-23 June 2000 (*3*).

How the paper refers to various aspects of HH/C IMCI has changed from one draft to the next. A draft of four "Intervention Options" was created in the fall of 2000 and then presented at several smaller meetings where NGO representatives were in attendance as well as at the Durban meeting. The Intervention Options underwent several rounds of revision. Different NGO programs and activities were reviewed, not with the aim of assembling a catalog of NGO activities at the community and household levels, but rather to find one or two examples to illustrate the different Intervention Options and activities. Finally, full drafts of the report went through several rounds of editing and revision with input from USAID BHR/PVC, CSTS, the BASICS II Project, and the CORE IMCI Working Group.

At a workshop held in Baltimore, Maryland from January 17–19, 2001 entitled "Advancing PVO/NGO Technical Capacity and Leadership for Household and Community IMCI" (*1*), presentations by PVOs were planned to illustrate different parts of the framework as it stood at that time. During the workshop participants reflected on the framework and made suggestions for how to refine it. A group met during the second day of the workshop to incorporate the various suggestions into a revised framework. The revised framework was presented to the workshop participants on the final day.

The term "Element" (formerly "Intervention Options") was selected by Workshop participants after consideration of several alternative terms. The term "Component" was already being used to designate the three components of IMCI (Improving the skills of health workers, Improving the health system; and Improving household and community practices). Participants were uncomfortable with the term "Options," as they wanted to emphasize that all three elements are integral parts of HH/C IMCI. Finally, the term "Definitions" was rejected because it suggests a lack of flexibility in implementation of HH/C IMCI.

In the weeks after the CORE workshop, the revised framework was presented at a meeting in Baltimore on January 22-24, 2001 on research related to HH/C IMCI hosted by Johns Hopkins University, at meetings hosted by UNICEF in New York of the IMCI Inter-Agency Working Groups on Measurement and Evaluation (February 5-6) and Household and Community IMCI (February 7-8) and to internal meetings and retreats of various PVOs and CORE Group Working Groups, USAID, CSTS and the BASICS II project. Comments and suggestions from these various meetings were sent to us and incorporated as best we could into the description of

the framework given in this document. The framework will be presented and discussed at the Annual Meeting of the CORE Group from April 23 to 27, 2001.

Despite the work that has gone into the preparation of this report, inevitably the work is incomplete. It represents only the first step in what will be a longer process of synthesizing lessons learned in the implementation of household and community-level interventions, and sharing these lessons with other partners. The report therefore is not intended to be a comprehensive survey of NGO experiences with household and community approaches, or lessons learned in NGO child survival programs, although it may provide the basis for such a survey to be carried out in the future.

II. Overview of the Components of IMCI

II.1 The IMCI Approach

Of the nearly 12 million annual deaths among children under age five, over 70 percent can be attributed to just five primary causes: pneumonia, diarrhea, malaria, measles and malnutrition. One response to this fact has been to create vertical, disease-specific programs directed at each of these causes at both the global and national levels. These vertical programs can claim a number of successes, such as the widespread acceptance and use of oral rehydration therapy and increases in immunization coverage in many countries. The presence of multiple disease-specific programs has, however, contributed to a number of administrative, political and technical difficulties in the delivery of health services.

The administrative difficulties have been particularly evident in decentralized health systems. Government health workers and PVOs/NGOs working at the district level have found their time consumed by endless cycles of meetings, courses and official visits from program managers based in the capital, each one focused on just one health problem or intervention such as ARI, diarrhea, immunization, breastfeeding or malaria. In many cases health workers at the district and community levels do not have time to apply the recommendations from one course or official visit before another one comes along.

A technical limitation of disease-specific control programs has been their failure to adequately address the needs of children at risk for or suffering from multiple diseases. A child seen at a health facility suffering from malaria, pneumonia and malnutrition might only be treated for malaria. A mobile team vaccinating children might miss the opportunity to promote other forms of disease prevention. Health training and health messages specific to vertical programs often compete with one another for the same limited staff attention and time: Should a sick child be evaluated according to the ARI protocol or the malaria protocol? Should the health education talk given to mothers in the waiting room be on mosquito nets or breastfeeding?

In response to these concerns, in the early 1990s the World Health Organization and UNICEF led the development and promotion of a new strategy known as Integrated Management of Childhood Illness, or IMCI (*11*). This initiative aims to significantly reduce mortality and morbidity associated with the five major causes of disease in children under five, and to contribute to their healthy growth and development. IMCI was first field tested in Tanzania in 1995 (*4*). Later that year it was introduced to six other "early use" countries and had expanded to 63 countries by June 1999. The household and community component was initiated in 1998 based upon the realization that a facility-based strategy would not reach significant portions of the population that did not have access to or chose not to use a health facility. IMCI is sometimes placed within the broader framework of Integrated Approaches to Child Health (*5*).

The IMCI strategy combines improved case management of childhood illness in first-level health facilities with aspects of nutrition, immunization, disease prevention, and promotion of growth and development. There are three components to IMCI, and interventions in all three components encompass both curative and disease preventive/health promotive activities (*4, 11*):

1) Improving the skills of health workers;
2) Improving the health system; and

3) Improving household and community practices.

II.2 Component #1: Improving the Skills of Health Workers

This was the first of the three components to be fully developed, has had the highest profile, and for many people has become synonymous with IMCI itself. This has happened for a number of reasons:

- The development of this component drew extensively from guidelines, courses and training manuals that had been developed by previous disease-specific programs, including WHO's CDD (Control of Diarrhoeal Diseases) and ARI (Acute Respiratory Infections) programs, the forerunners of the current WHO Division of Child and Adolescent Health and Development; and
- Many governments find interventions involving health worker training much easier to implement than interventions involving systems or communities. In many countries there is little or no tradition of governments working with communities, and there may be no obvious infrastructure at the community level that governments can use to engage people in IMCI activities.

The cornerstone of this component of IMCI is a set of algorithms (flow charts) and guidelines for the integrated case management of diarrhea, pneumonia (ARI), fever, malaria, measles, malnutrition, and the promotion of immunization in health facilities. Use of these algorithms ensures that health workers address not only the most obvious problem a sick child has, but a range of nutritional and infectious disease problems that commonly affect children in that country. Each country first goes through a process of adapting the algorithms and guidelines, taking into account local patterns of disease prevalence, clinical presentation and drug resistance.

For example, the generic algorithms and guidelines deal with the diagnosis and treatment of malaria and thus need to be modified for areas where there is no malaria transmission. Other common associated conditions can be added to the *Generic Guidelines* such as HIV/AIDS and dengue fever. These adapted guidelines were first field-tested in Tanzania in 1995 (*4*), and later in other countries including India, Uganda, Kenya and The Gambia (*15, 18, 20, 23*). Over 60 countries have now adopted IMCI as their official policy, and are starting the process of adapting the treatment algorithms and training health workers.

An 11-day course trains health workers in the skills needed to apply these algorithms. These skills are developed as health workers assess and treat children with each of the major signs and symptoms in the health facilities where the training is taking place. Training takes place in a teaching hospital or other facility that provides a classroom and a sufficient number of actual cases of children with the five conditions. In addition, about 500 pages of reading are required.

Health workers have generally reacted positively to the 11-day course, and evaluations of the training have documented clear improvement in health worker skills (*10, 21*). Despite these successes, scaling up of the approach to involve all health workers treating sick children in all health facilities has proven difficult in many countries for the reasons such as:

- Many health workers find that the course is too long, and that they cannot afford to take 11 days away from their work for training. This has led a number of countries, especially in Latin America, to experiment with shorter courses, and/or alternative courses. Some IMCI programs are starting to experiment with distance learning via CD-ROM and web technology;
- Some health workers, especially those with limited formal training who practice in peripheral facilities (health posts, aid stations), find parts of the guidelines too complex to understand and use, which has led countries to develop modified and simplified courses; and
- Some health workers report that the guidelines are impractical, given the number of children they see in their health facilities. Application of the guidelines involves spending considerably longer than health workers would normally spend in assessing and selecting treatment for each child and in counseling the caretaker in how to administer the treatment.

Although training of facility-based health workers has not been a traditional focus of US-based NGOs (PVOs), a number of them now have strong commitments in this area in partnership with Ministries of Health.

II.3 Component #2: Improving Health Systems

At the health system level, policies that support IMCI's integrated approach are put in place. Therefore, IMCI concerns itself with improving the infrastructure to provide equitable and sustainable solutions to the problems of childhood illnesses. Initial meetings with government ministers to inform and advocate for the strategy and its advantages are followed by orientation and training of other high-level officials and consultations with the Ministry of Health (MOH) in each country. Available resources are evaluated, partnerships are created throughout the country, and goals are set to develop systems which will maintain the IMCI program and adapt it to changing conditions long after the initial stages of training and implementation have been completed. US-based NGOs (PVOs) are playing an increasing role in this component of IMCI. In a number of PVO child survival programs, PVOs are working with decentralized Ministry of Health (MOH) teams at the district level to implement many of the activities that are part of this component.

Issues to be addressed in the implementation of the second component of IMCI include (*4*):

- Drug availability,
- IMCI planning and management,
- Organization of work at health facility level,
- Health information systems, and
- Health sector reform.

All of these issues have been included in earlier primary health care initiatives and programs, and the approach taken is sometimes not specific to IMCI. Their inclusion again in IMCI programs is part of a strategy to address "missed opportunities for implementation" in previous programs.

Drug availability: The complex issues of drug procurement and drug distribution have proved to be a serious challenge in all countries implementing IMCI. Vigorous efforts are needed on this front. Some recommendations include (*4*):

- Involve national drug authorities early in IMCI planning,
- Work to have IMCI drugs included in the national Essential Drugs Program (EDP), and approved for use at the appropriate level of health system by IMCI-trained staff, and
- Identify temporary solutions in districts starting IMCI while working for systems change to improve drug availability.

IMCI planning and management: It is crucial that national planning for IMCI be made in collaboration with all MOH divisions and interested partners to ensure a correct understanding of major steps. Also, districts should be involved early in the planning process, assisting in integrating IMCI into their development plans, building upon ongoing programs and management structures. This is a point where NGO experience in planning and implementing community-based programs can be invaluable. Supervisory systems at national and district levels will need to be identified and strengthened through training. Another important component of planning is the use of integrated health facility assessments to ensure that the equipment, supplies and procedures necessary for IMCI tasks to be performed adequately are in place. In addition, implementers can work to train health workers in a facility in as short a time period as possible.

Organization of work at health facility level: For IMCI to become a sustainable and effective intervention strategy, other aspects of the health system should also be in place. These include efficient organization of health services delivery, application of quality assurance management methods (*13*), establishment of systems for maintaining an adequate supply of essential equipment, and adequate financing of health services while maintaining access for the poor. It is crucial also that systems for referral of sick children from first-level facilities to higher-level facilities offering advanced care be organized and improved in quality (*12*). Finally, there will need to be incentives for and monitoring of health worker performance.

Health information systems: Early collaboration with the MOH division responsible for health information systems (HIS) is essential during IMCI planning. After examination of national HIS and IMCI classifications, efforts should be made to harmonize the two into one system of classification (*19*). It is also essential to develop recommendations and procedures to help health workers meet the HIS reporting requirements adequately after training in IMCI.

Health sector reform: Health sector reform strategies include identifying an essential package of health services, decentralization of planning and management of health services to district level, strengthening management of public health care, improving the function of ministries of health, defining the role of private health care providers in the health system, designing alternative financing mechanisms and improving financial management of the health sector.

The health sector reform (HSR) process involves reviewing and reorganizing the structure of the health system in a country, often in collaboration with bilateral and multilateral organizations (*25, 26*). The focus of reforms depends on the country. The first step in the process of introducing HSR is to review and revise existing national policies and strategies, or if necessary, to develop new ones. Many aspects of HSR are relevant to and consistent with IMCI strategies and activities.

The IMCI Strategy can play an important role in most aspects of HSR, in particular through:

- Improving cost-effectiveness of essential child health care services,
- Strengthening capacity for decentralized management at district level,
- Improving quality of health care for children,
- Cost savings, and
- Strengthening drug supply and management.

Early experience with IMCI implementation has led to greater awareness of the need to improve drug availability, support effective national- and district-level planning and management, and address issues related to organization of work at health facilities. In all countries with significant experience to date, IMCI has served as a catalyst for identifying substantial weaknesses in the public health system. More experience is needed to define how this potential can be harnessed for further improving the health system.

II.4 Component #3: Improving Household and Community Practices

The third component of IMCI paradigm, referred to here as Household and Community IMCI, will be the focus of the remainder of this report. Implementation of this component of IMCI is a complex undertaking, and depends on multiple actors, entry points and strategies. While HH/C IMCI may be a new activity for some organizations, implementation at the community and household levels of the different activities that fall under HH/C IMCI has been a long-standing focus of NGOs. NGOs work closely with communities and have developed programs that are adapted to local epidemiological patterns, resources and patterns of social and political organization. The report will present a framework, developed in collaboration with the CORE Group, that presents different ways NGOs have implemented community approaches to child health and nutrition. Their experience is invaluable, as they have already faced many of the issues in implementation that national IMCI programs are now encountering. In many cases they have developed approaches to implementation at the community or district level that could be scaled up in partnership with national IMCI programs.

III. A Framework for Planning and Implementation of Household and Community IMCI

III.1 A Framework for Planning and Implementation: Why is it Needed?

There has been consensus at recent meetings such as The International Workshop on Improving Children's Health and Nutrition in Communities held in Durban, South Africa that the focus of the third component of IMCI is on improving household and community practices (*3*). Despite this consensus, a common frustration voiced by many active in the efforts to improve child health and nutrition is "I still am not sure what Community IMCI is." The diversity of presentations and opinions presented at meetings on HH/C IMCI is stimulating, but inevitably leads to discussion of how broad the concept of HH/C IMCI should be: is it all-encompassing, dealing with all factors affecting the health and development of young children, or should it focus on a narrow range of specific behaviors to be promoted at the community and household levels? At the present time it appears that this question will never have one single answer. What HH/C IMCI "is" will depend on the characteristics of the communities where activities are being implemented, as well as the capabilities of the different organizations working in partnership with the communities to improve child health and nutrition.

This section of the report presents a revised framework for HH/C IMCI based on feedback from participants who attended a workshop held in Baltimore, Maryland from January 17–19, 2001 entitled "Advancing PVO/NGO Technical Capacity and Leadership for Household and Community IMCI" (*1*). During the workshop participants reflected on the framework and made suggestions for how to refine it. The framework addresses the issue of "how" Community IMCI can be implemented at the community level. This framework enables implementers and their colleagues to better communicate and plan public, private sector, and household interventions that can improve child well-being and reduce child mortality and morbidity in communities within the overall guidelines of the HH/C IMCI strategy established by UNICEF and its partner organizations.

III.2 Overview of the Framework

Participants at the CORE Workshop in January 2001 defined HH/C IMCI as "the optimization of a multi-sectoral platform for child health and nutrition that includes three linked requisite elements" (see Figure 1 and Table 1 on following pages) (*1*). These programmatic Elements are means to work within communities to improve health, nutrition and development outcomes for children and their families. The three Elements can also be phrased in terms of programmatic objectives, and this may prove more useful for program planning.

Table 1. The Three Programmatic Elements in the HH/C IMCI Framework

Elements		Examples of corresponding objectives
Element 1:	Improving partnerships between health facilities (and services) and the communities they serve.	• Form partnerships between health facilities (and services) and the communities they serve • Increase utilization of health facilities/services • Establish mechanisms for community feedback on and/or management of health facilities/services
Element 2:	Increasing appropriate and accessible care and information from community-based providers.	• Increase quality of care from community-based providers • Increase promotion of preventive practices by community-based providers • Decrease harmful practices of community-based providers
Element 3:	Integrated promotion of key family practices critical for child health and nutrition.	• Increase adoption of key family practices for health, nutrition and development • Engage communities in the selection of behaviors to be promoted and identification of actions to be taken

The Multisectoral Platform addresses social, economic and environmental factors that facilitate or hinder the adoption of the Key Family Practices. It provides an opportunity for NGOs and other organizations to work with local governments and other partners to develop innovative approaches to the promotion of child health, nutrition and development.

The HH/C IMCI implementation framework distinguishes HH/C IMCI programs from community-based programs implemented under the broader definition of Comprehensive Primary Health Care (*27*). Each of the elements focuses on an institution or set of people with a critical role to play in efforts to promote appropriate child care, illness prevention, illness recognition, home care, care seeking, and treatment compliance practices.

Figure 1. Framework for Planning and Implementation of Household and Community IMCI (Design by Kathy Strauss , BASICS II and Chris Bessenecker, PCI)

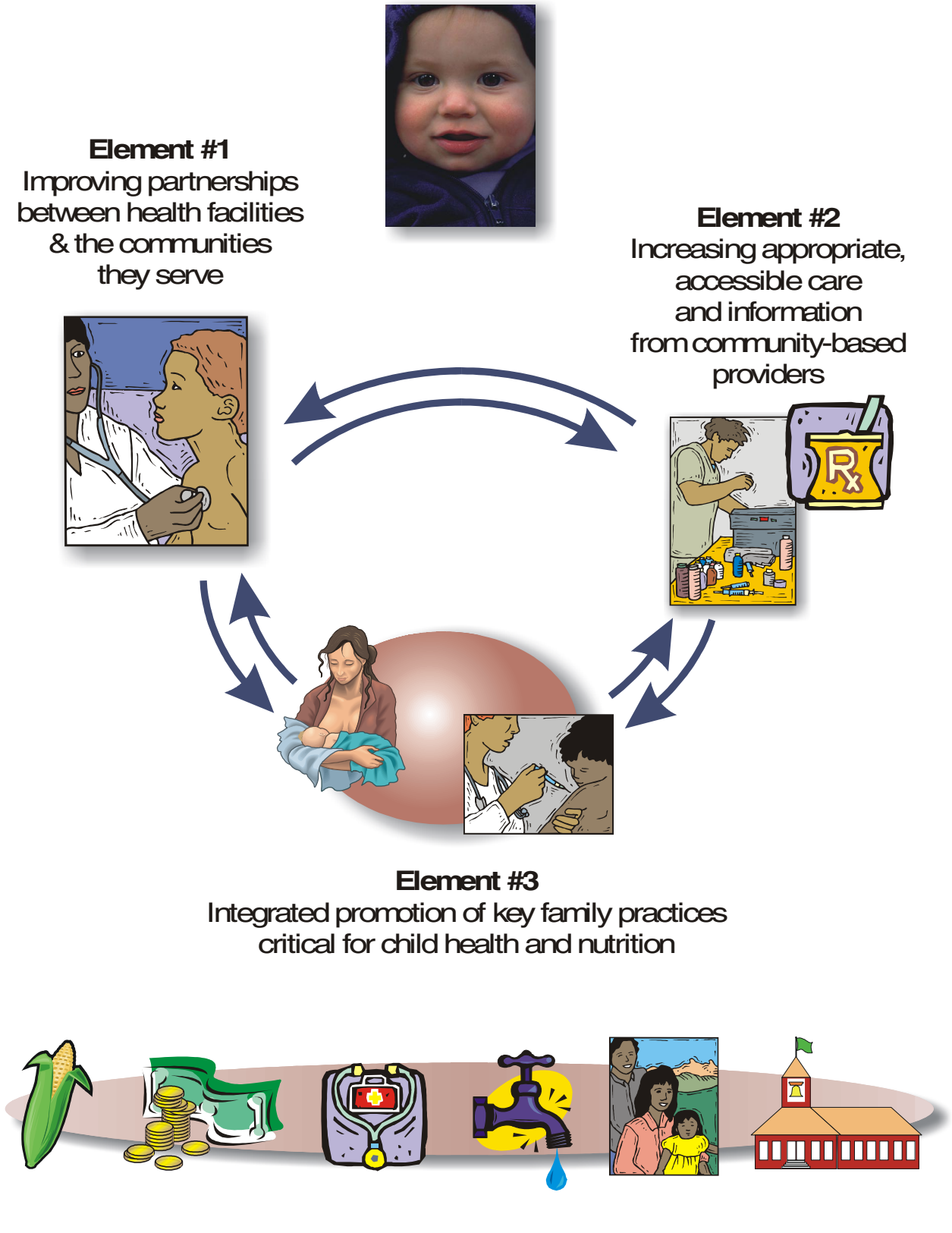


Table 2. Roles in Implementation of the Three Elements in the HH/C IMCI Framework

Element	Who is involved?	Examples of their roles in implementation
ELEMENT ONE Improving partnerships between health facilities or services and the communities they serve	• Ministries of Health, NGOs and other organizations that operate health services	• Establish policies that promote community input into the management of health facilities and services • Work with communities to recruit and retain qualified health workers at all health facilities • Reassess policies regarding obligatory transfers of health personnel to promote greater continuity
	• Health personnel based in government or NGO health facilities • Health personnel in mobile outreach teams (vaccination, vitamin A) • CHWs and other volunteers	• Recognize local knowledge and abilities • Improve inter-personal counseling • Use understandable/simple language with community members • Increase community outreach • Involve community members and leaders in planning and implementation • Increase accountability for quality of services • Raise awareness in the community about improvements to health services • Educate about signs requiring care-seeking from facility
	• Community management boards for health facilities • Village health committees • Local governments • Women's groups • Community members	• Advocate that caretakers increase usage of improved services • Provide community-based data to health facilities to plan appropriate promotional and outreach events • Give feedback on quality of services • Participate in decisions about management of services • Provide additional resources through local initiatives
ELEMENT TWO Increasing appropriate, accessible care and information from community-based providers	• Community health workers and other volunteers • Private providers • Injectionists • Traditional healers and birth attendants • People who sell drugs: pharmacists, shop owners, drug vendors	• Provide effective care for sick children and avoid harmful practices (unsafe injections, prescribing or sale of unsafe or expired drugs) • Refer sick children to appropriate health facilities when advanced care is required • Promote preventive behaviors such as exclusive breastfeeding, vaccination, and use of condoms and insecticide-treated bednets
	• National and district health services • NGOs and other organizations • Medical syndicates	• Develop simplified algorithms for case management by community-based providers • Incorporate IMCI into pre-service training of providers • Develop courses and other interventions to improve the quality of care • Ensure supervision and on-going training of community-based providers • Institute licensing of certain classes of providers • Ensure supply of essential drugs and other commodities at the community level (e.g. Drug revolving funds) • Provide appropriate incentives for CHWs and other volunteer workers
ELEMENT THREE *Integrated* promotion of key family practices critical for child health and nutrition	• Mothers, grandmothers, fathers of young children • Other caretakers of young children: siblings, aunts etc.	• Promote physical growth and mental development of young children • Adopt practices to prevent disease • Provide appropriate home care • Seek care outside the home when appropriate
	• National and district health services, NGOs and other organizations, CHWs	• Engage communities in the selection of behaviors to be promoted and identification of actions to be taken • Develop integrated national and district behavior change strategies • Promote key family practices through mass media and interpersonal channels

III.3 Relationship Between the Framework and the Pathway to Survival

By working through all three elements, HH/C IMCI engages families for better health and nutrition through three major points of influence.

Element 1 focuses on formal health services, including fixed health facilities and outreach services, operated by governments and NGOs.

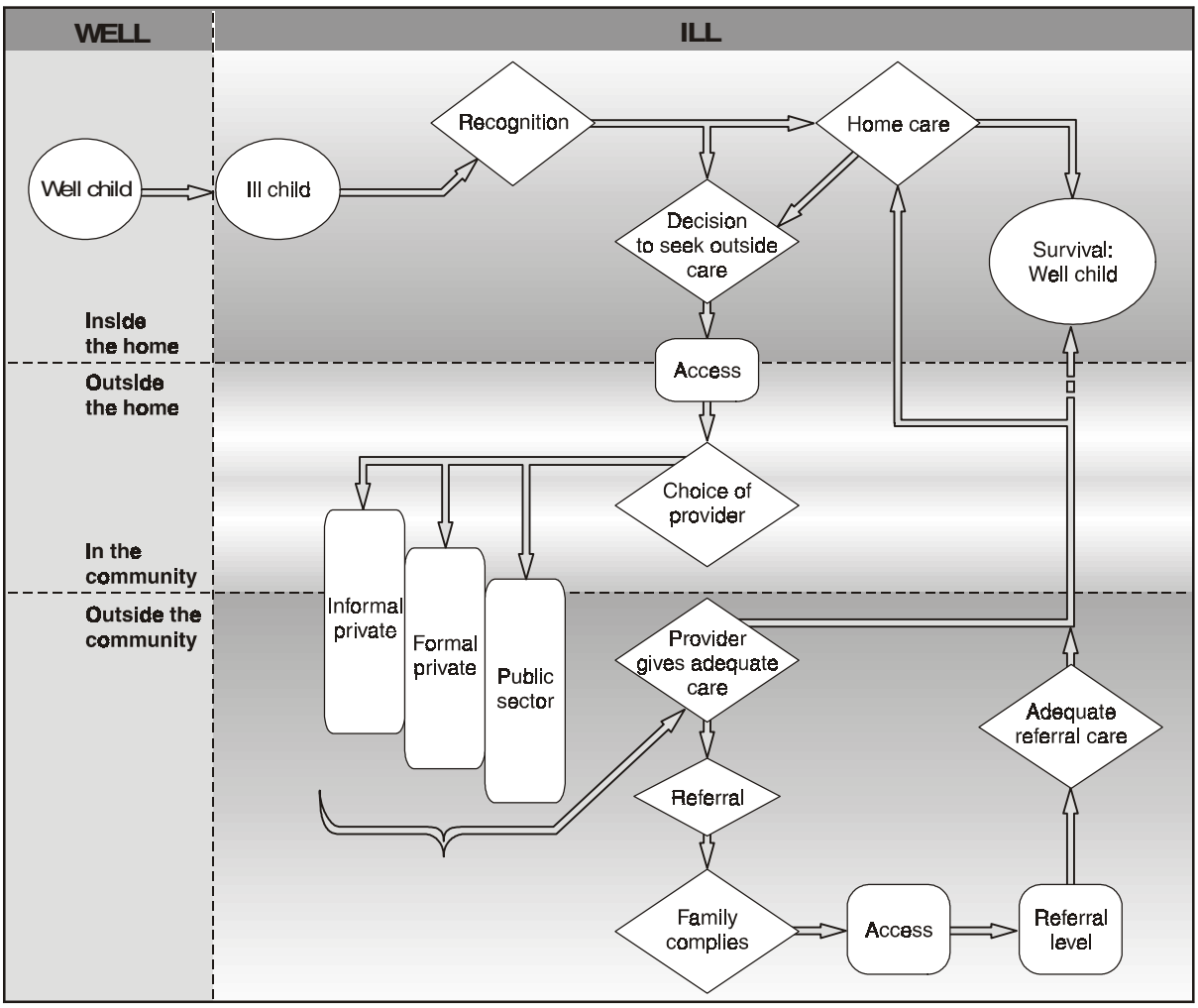
Element 2 focuses on the private and informal sectors, including Community Health Workers and other volunteers, private providers, drug vendors and traditional healers.

Element 3 focuses on the practices of the parents and other caretakers of young children at the household and community levels.

The three Elements can also be related to the Pathway to Survival developed by the BASICS I Project, which is illustrated in Figure 2 (*28, 29*). The Pathway identifies two boundaries to integrated care of children: wellness/illness and care inside and outside the home. The Pathway indicates that most care (treatment and prevention) of childhood illness occurs outside of health facilities in either the home (Element #3) or from community-based providers (Element #2).

The upper third of Figure 2, "Inside the home," corresponds more or less to Element 3. The middle third of Figure 2, "Outside the home, In the community," corresponds to Element 2. The bottom third of Figure 2, "Outside the community" relates to much of what is contained in Element 1. A limitation of Figure 2 is that it highlights the management of the Ill Child, and provides little details on services and practices related to the Well Child such as immunization, breastfeeding, weaning, hygiene, water/sanitation, and other preventive services.

Figure 2. The Pathway to Survival *(28, 29)*



IV. ELEMENT ONE: Improving Partnerships Between Health Facilities or Services and the Communities They Serve

The first programmatic Element focuses on health care facilities and services operated by governments or NGOs and interactions between health care workers and community members. There are a number of issues involved in improving these partnerships. The potential for partnership may initially appear to be limited, as both health workers and community members are constrained by limited time and resources:

- Health workers try to cope with a heavy work load, combined with an inadequate supply of essential drugs, lack of transport, irregular salary payments and communication difficulties; and
- Community members may have to deal with user fees they find unaffordable, long waits to be seen, poor quality service, lack of essential drugs, and lack of transport to referral facilities.

The end result of this situation is often a strained relationship between health workers and community members. Symptomatic of this strained relationship is rude treatment of users of services by health workers, and low rates of utilization of services by the community. IMCI seeks to transform this situation in part by improving the skills of health workers (Component #1) and improving the functioning of health systems (Component #2).

While implementation of the first two components of IMCI can make an important contribution to improving the quality of services, the first two components are not sufficient. Solid partnerships between health facilities or services and the communities they serve are key to consolidating and sustaining the improvements made to services through implementation of the first two IMCI Components. These partnerships create channels through which communities can voice their concerns and advocate for improvements to services.

The vision for this first programmatic Element is illustrated in Table 3. Table 3 could also be formulated in terms of program objectives or indicators, such as “decrease proportion of vacant posts for health workers in the district from 25 percent to 10 percent” or “increase proportion of caretakers/parents who seek care from health facilities when their children have danger signs from 20 percent to 60 percent.”

Table 3. A Vision for Partnerships Between Health Facilities or Services and the Communities They Serve

Prior to implementation		After implementation
• High turnover of health personnel, low motivation and morale		• Lower turnover of health personnel, higher motivation, strong support from communities
• Poor quality of health services and no accountability for their quality		• Higher quality of health services and health workers increasingly accountable to community for quality of services
• No community input into services offered	→	• Active role for community in management of facilities/services
• Limited outreach by facility-based personnel		• Regular outreach by facility-based personnel
• Low utilization of services and delayed care-seeking for sick children		• High utilization of services and early and appropriate care-seeking for sick children

The active engagement of three groups is important for this programmatic Element:

1. Ministries of Health, NGOs and other organizations that operate health services;
2. Health personnel based in government or NGO health facilities, and/or mobile outreach teams that deliver services such as routine vaccination, distribution of Vitamin A capsules, antenatal checkups; and
3. Community members, acting either directly or collectively through management boards for health facilities, village health committees, Community Health Workers (CHWs) and other volunteers, local governments, women's groups, and religious or other institutions.

IV.1 Role of Ministries of Health and NGOs

Ministries of Health, NGOs and other organizations that operate health facilities and services have the opportunity to create a policy environment that fosters collaboration between health workers and communities. This includes establishing policies that foster community input into the management of health facilities and services, and reassessing policies regarding obligatory transfers of health personnel to promote greater continuity. Frequent transfer of health workers from one facility to another makes it impossible to establish a lasting collaboration between facilities and communities. Reasons for frequent transfers of personnel by Ministries of Health, such as lack of personnel in some parts of the country, need to be understood and discussed. Where posts are vacant, governments and NGOs can work with communities to recruit and retain qualified health workers.

Ministries of Health, NGOs and other organizations such as WHO, PAHO and UNICEF also have an important role in designing training courses or other activities to support the implementation of this Element. Health workers may have little or no experience in interacting with communities. They may benefit either from training in areas such as community organizing, participatory planning methods and inter-personal counseling skills, or from spending time with an existing program in another part of the country where community-based health workers are active in community work. Once training is completed, community outreach activities by facility-

based health workers can be supported by ensuring that health workers have transport, and taking outreach activities into consideration in the supervision and promotion of health workers.

Several tools have been developed to provide direction to facility-based health workers on community outreach, demand creation and promotion of improved services. WHO has developed a manual for health workers entitled "Working with Community Organizations," while PAHO has created the "Talking with Mothers" module. A five-day IMCI CHW Training Course was developed by PAHO in collaboration with a group of NGOs in Latin America. The course trains CHWs to perform tasks such as recognizing danger signs and referring children with these signs to health facilities. Unlike CHW training courses developed by some programs in Africa and Asia, the PAHO course does not train CHWs in diagnosis and treatment with antimicrobials. This training course has been field tested in Colombia, El Salvador, Nicaragua, Dominican Republic and Ecuador.

IV.2 Role of Health Personnel Based in Government or NGO Health Facilities

Health workers have the opportunity to reach out to the community and increase utilization through improved inter-personal counseling when people come to health facilities, increased community outreach, raising awareness in the community about improvements to health services, and education of community members about danger signs such as rapid breathing, chest indrawing and convulsions requiring care-seeking from facility. Finally, health workers can become more receptive to input from the community, and more accountable for the quality of the services they provide. Through training in Quality Assurance Management Methods and other techniques, health workers can come to see input from the community as constructive and useful, rather than as complaining (*13*).

Health workers may increase the scope of facility-based services, and modify the content of services in response to input from the community. Based on community input, service norms are modified to make services more convenient, acceptable, and culturally sensitive to potential users, e.g. addressing such issues as limited service hours, privacy, waiting times, lack of transparent and consistent monetary charges, special treatment for some clients, reliability of medicine supply, giving essential information to clients, access of family members to interned patients, room temperature, return of the placenta, and inability of some providers to speak local languages.

The services provided at a health care facility may be exclusively clinical, or may include a limited number of non-clinical activities such as health education. If a health care facility is committed to promoting the full range of key family practices, as described later in the section on programmatic Element #3, then additional activities such as health fairs and expanded outreach activities will need to be developed.

IV.3 Role of Community Members, Community Groups, and CHWs

There is considerable scope for community participation in relation to this programmatic Element. This participation can be discussed at four levels:

- Increased appropriate utilization of health services,
- Increased community input and feedback on health services,

- Community advisory boards for health facilities, and
- Community management of health facilities.

Increased appropriate utilization of services. While this is a limited kind of participation, it is an essential part of efforts to decrease child mortality. Many conditions cannot be adequately managed in the home, and require care-seeking from health facilities. Utilization of other services related to disease prevention, nutrition and development is also important. Utilization of services also provides communities with experience upon which to base their feedback on quality of services.

Increased community input and feedback on health services. In many, if not most, health facilities there is no formal mechanism for communities to provide regular feedback to facility-based health workers on their perceptions of quality of the services and their suggestions for improvement in the services. An initial step may be to elicit community input through group meetings or through a household survey. A further step may be to set up regularly scheduled meetings with the community to hear their feedback on the services. Where community-based Health Information Systems exist, communities can provide data to facilities on vital events, program coverage and perceptions of quality.

The CHANGE Project is presently developing the "World Views Comparison" tool which can be used for this purpose (*30*). It assists groups with different perspectives in understanding each other's values and priorities, setting the basis for finding common ground in dealing with a health challenge. This tool/approach can be applied when people from different cultural backgrounds (e.g., different organizations, the public and private sector, or health workers and patients) have to work together to achieve a health outcome. In Cochabamba, Bolivia, USAID's MotherCare project identified mothers' and health care workers' ideas of what should happen at a delivery. Laying out their perceptions with this tool facilitated negotiation of changes that both could accept.

Community advisory boards. A further level of participation can be for the facility to work with the community to establish community advisory boards consisting of community representatives who meet regularly with facility-based health workers and serve as a channel of communication from the community to the health facility and back.

Community management of health facilities. The highest level of community participation occurs when a representative community board assumes responsibility for management of the health facility, and of the health of the entire community. For the facility this includes hiring and supervision of personnel, financing and cost recovery, and making decisions about the types of services to be offered. Sometimes the focus is only on the health facility, instead of promoting health, nutrition and development for the entire population living within the catchment area of the facility. Beyond the facility, communities can work with health personnel to identify important determinants of health and illness in the community, and develop innovative approaches for addressing them. One example is the "Comités Locales de Salud" (Local health committees or CLAS) in Peru. These are community groups that have assumed responsibility for management of Ministry of Health facilities and the services they offer in many parts of the country, sometimes in partnership with a local NGO. This degree of participation is unusual, although many NGOs have helped form community-based health management committees that support and advise facilities in their planning of health programs.

IV.4 Relationship to the First Two Components of IMCI

Implementation of the first two components of IMCI (improving skills of health workers and improving the health system) optimally should occur either prior to or early in the implementation of this programmatic Element for several reasons. First, improving the skills of health workers in assessing and treating sick children arguably should precede any training in community outreach. If their clinical skills are poor, they may have less credibility when they go to conduct community outreach. Second, if improvements to health services have not been made, it does not make sense to try to increase utilization of these services. Increased utilization in the absence of improved services will lead to frustration as community members deal with long lines, poor communication by health workers and drugs that are not in stock.

There are many settings, however, where implementation of this programmatic Element may precede implementation of the first two components of IMCI. Community management of a facility may be a necessary first step leading to building or renovating a facility. Community commitment to a facility may facilitate recruitment of health workers for posts that previously were unfilled. Communities should also have a voice in deciding where to locate new health facilities.

IV.5 How Element 1 Differs from Previous Primary Health Care Programs

At the facility level. Element 1 differs from previous primary health care programs in several important ways. First, linkages are made to implementation of IMCI in facilities. This is important, because the improvements to quality that result from IMCI implementation facilitate the formation of partnerships with communities. In addition, facilities increasingly are held accountable to communities for quality of services they provide.

At the community level. The Ministry of Health traditionally has shouldered the entire responsibility for personnel, equipment, training, supervision and quality of health services. Limited personnel and resources have meant that these various functions typically are only partially carried out. Element 1 is different in that it proposes a significant role for communities in maintenance of service quality through their feedback to health personnel. Communities also engage in the management and sustaining of various systems improvements.

IV.6 Innovative NGO Approaches to the Implementation of This Element

Ministry of Health officials often define the health system only in terms of the public health facilities and government health workers supported through their budget. NGOs have an important role in helping local partners to take this first step into developing a long-term collaborative relationship with local communities. NGOs can share and disseminate approaches they have developed for:

- Building demand for services and increasing utilization,
- Use of participatory research methods to elicit community feedback on health services,
- Working with representative community groups, and
- Training of facility-based health workers and CHWs.

This is particularly true of child survival programs in which US-based NGOs (PVOs) work to build the capacity among decentralized Ministry of Health teams or local NGOs to implement and sustain community-based activities. Several examples of innovative NGO approaches to the implementation of this programmatic element presented at the CORE Workshop in January 2001 (*1*) are described below.

Co-management and co-financing of health services in Cambodia (*31, 32*)

The Cambodian health care system is faced with weak management, low utilization of services, lack of basic equipment and supplies and low motivation among health staff. A Catholic Relief Services (CRS) project started in Battambang Province in 1993 supported strengthening of health services, creation of village health committees and recruitment and training of village health volunteers and traditional birth attendants. After consulting with local authorities, in mid-1998 CRS proposed a Co-Management and Co-Financing (CMCF) model as a strategy for ensuring quality health services, sustainability and community involvement in financing and management. CMCF committees are composed of two elected representatives (one woman and one man) from each village. Committee members set policies on user fees and exemptions, actively solicit feedback from health personnel and community members, monitor levels of utilization of services and coordinate outreach activities. An external evaluation in May 2000 found significant increases in utilization for health centers that had active CMCF committees. Project staff felt, however, that CMCF should not be implemented before an acceptable level of health center service quality had been reached. CRS staff have put together a detailed implementation guide based on their experiences which is described in Section XIII.2 of this report (*31*).

A key barrier to accessing care is financial. Large decreases in utilization have been documented in some cases where user fees have been implemented (*33*). In this and other cases the community management of facilities can play a crucial role in maintaining utilization not only by setting fees at an affordable level, but also by allowing for credit or alternative in-kind payment mechanisms.

Increasing utilization of services for prevention and treatment of malaria in Uganda

This example describes the approach MIHV has taken in Uganda to increase demand for malaria prevention and treatment services (*34*). It demonstrates how NGOs can work with facility-based personnel to reach out to communities in innovative ways. MIHV in Ssembabule District, Uganda, developed "Malaria Awareness Days" (MADs) to provide malaria control and treatment information at the village level, age-appropriate treatment of malaria, and link the community with their nearest health care providers. MIHV staff with MOH counterparts conduct a three-hour MAD on a weekly basis in different villages. MADs can be held at the request of communities or in response to information collected during village-level disease surveillance data analysis. All community members are encouraged to attend and MIHV helps mobilize other nearby communities to join in as well. During the MADs, health staff show videos on malaria and bednets, give talks on malaria control and treatment, distribute health education materials, and hold competitions (from physical tug of war games to knowledge games) with prizes of bednets, mosquito coils and insecticides. Throughout the program health workers provide treatment for cases diagnosed syndromically, raise awareness of services available at health facilities, encourage communities to access these services, and give referrals for more serious

cases. The program provides education in a non-traditional atmosphere, access to community level services, and reinforces knowledge of signs/symptoms of malaria and the need for proper case management.

Improving follow-up in the home by facility-based personnel in the Dominican Republic (*35*)

The Order of Malta Maternal and Child Clinic is a private clinic in a poor neighborhood of Santo Domingo, Dominican Republic, that receives technical and financial assistance from Project HOPE. After IMCI training of clinic staff, a new form and codes were introduced to record information about children visiting the clinic, based on modifications to the standard IMCI form. The form was not only used in the clinic, but was used by community outreach staff to decide which children need follow-up in the home, based on standard criteria. The impact of these and other strategies were assessed through operations research, and significant increases were seen in the proportion of caretakers who brought their children back for scheduled follow-up visits. The fact that the clinic has both facility and community-based personnel allowed it to develop a strategy for IMCI implementation that integrates all three IMCI components: improved health worker skills, improvements to the health systems and improved promotion of Key Family Practices at the household and community levels.

V. ELEMENT TWO: Increasing Appropriate, Accessible Care and Information From Community-based Providers

V.1 Introduction

The first point of contact for the care of sick children and for health information is often community-based providers. The second programmatic Element focuses on the full range of providers who diagnose and treat sick children outside of health facilities:

- Community health workers and other volunteers,
- Traditional healers and midwives,
- Physicians in private practice, and
- Other unlicensed providers,

as well as providers who distribute and sell drugs only:

- Pharmacists,
- People who sell drugs from drug shops, grocery stores and market stalls,
- Ambulatory drug vendors, and
- Injectionists.

These providers are a major source of care, in many countries far surpassing the formal health system in terms of patient volume (*36-38*). They are of particular importance for communities where long distances and/or difficult terrain separate people from public health facilities, although some recent studies suggest that factors other than distance are important determinants of utilization (*39*). When people do reach these facilities, shortages of health workers with formal training may mean that care is unavailable.

Even where health worker skills have been improved through implementation of the first component of IMCI, and geographic access is good, many children will continue to receive treatment outside of public health facilities. This is true even where there is strong demand in the community for the child health services they provide. In addition, there is recognition that the public sector will have difficulty ever meeting the demand for services, given the limited number of facilities relative to the size of the population in many countries. This lends support to the view that the key aim of HH/C IMCI should be to improve the quality of care sick children receive outside of public health facilities. The first and only point of contact for health information and treatment is often a community-based provider.

Program managers are faced with different challenges for each type of provider, as shown in Tables 4 and 5. CHWs and other volunteers are typically recruited, trained and supervised by health programs. Programs therefore tend to have greater control over the work they perform, so harmful practices are less common. However, because they are working as volunteers or receive a nominal salary, many programs experience high rates of attrition, so incentives become a major concern for the program manager.

Attrition is of limited concern for providers in the private for-profit sector, as payments from their established clientele maintain them in practice. Program managers, however, have less control over the quality of care they provide, as they neither recruit, train nor supervise them.

Despite educational efforts, the profit motive may sustain unsafe practices such as reuse of injection equipment without sterilization.

Table 4A. Roles in HH/C IMCI for Two Different Types of Community-based Providers.

		CHWs and other volunteers	Physicians and paramedical personnel in private practice
Roles in HH/C IMCI	Prevention, nutrition, mental development	Generally strong, need to solidify and expand to additional practices	Often weak, need to find innovative ways to engage providers in preventive care
	Curative care	Generally weak, may want to strengthen skills in curative care	Generally strong, but need to improve quality of care

Table 4B. Typical Issues Faced by Program Managers for Two Different Types of Community-based Providers.

		CHWs and other volunteers	Physicians and paramedical personnel in private practice
Issues of concern	Quality of care	Moderate concern	Moderate to high concern
	Harmful practices	Low concern	Moderate to high concern
	Attrition	High concern	Low concern

The active engagement of two groups contributes to this programmatic Element:

1. National and district health services, NGOs and other organizations that operate health services, medical syndicates; and
2. Community-based providers.

Community-based providers can:

- Provide effective care for sick children and avoid harmful practices (unsafe injections, prescribing or sale of unsafe or expired drugs);
- Refer sick children to appropriate health facilities when advanced care is required; and
- Promote preventive behaviors such as exclusive breastfeeding, vaccination, and use of condoms and insecticide-treated bednets.

Table 5. A Vision for Increasing Appropriate, Accessible Care and Information From Community-based Providers

	Prior to implementation		After implementation
Physicians in private practice, traditional healers, drug vendors, shop owners etc.	• Quality of care deviates greatly from IMCI guidelines • Unsafe injections and other dangerous practices • Sale of dangerous and expired drugs • Limited role in promotion of prevention • Limited referral of seriously ill children to health facilities	→	• Quality of care closer to IMCI guidelines • Significant decrease in unsafe injections and other dangerous practices • Significant decrease in sale of dangerous and expired drugs • Expanded role in promotion of prevention • Early and appropriate referral of seriously ill children to health facilities
CHWs and other volunteers	• Limited involvement in curative care and referral of children to health facilities • High rates of attrition due to lack of incentives • Limited supervision of activities	→	• Expanded involvement in curative care and increased referral of children to health facilities • Decreased rates of attrition, sustainable incentives in place • Systematic "support-vision" of activities

Ministries of Health, NGOs, other organizations providing health services and international organizations can provide leadership for six principal activities to support the implementation of the second programmatic Element:

1. Upgrade the skills of community-based providers in curative care
2. Engage community-based providers in the promotion of prevention, nutrition and development;
3. Institute systems to improve referral of patients (and communication between households, community-based and facility-based providers);
4. Ensure supply of essential drugs at the community level including treatment for pneumonia and malaria through drug revolving funds and community pharmacies;
5. Develop interventions to decrease harmful practices associated with treatment outside of health facilities (unsafe injections, treatments unsafe for children, overuse and underdosing of antimicrobials favoring emergence of drug resistant microorganisms); and
6. Institute appropriate incentives to decrease rates of attrition among CHWs and other volunteers.

The rest of this chapter will describe each of these activities in more depth and provide examples of programs meeting this challenge.

V.2 Activity #1: Upgrade the Skills of Community-based Providers

A number of disease-control programs and PVO child survival projects have worked to improve the diagnostic and treatment skills of these providers. Diarrheal disease control programs have worked with community health workers, traditional healers, private physicians, pharmacists, drug shop owners and others to decrease the sale of purgatives, antibiotics and antidiarrheal drugs and promote oral rehydration therapy for children with diarrhea (*40-43*). Malaria control programs have worked with malaria volunteers, shop owners, traditional healers and mothers' groups to promote early treatment of presumptive cases of malaria in the community (*37, 44-52*).

These and other interventions have suffered from two principal limitations: 1) partnerships with different community-based providers usually have not been maintained once funding for disease-specific programs has ended, as pointed out in a recent review of interventions with private practitioners (*38*); and 2) these interventions have promoted the treatment of only one disease at a time. Sick children brought to a malaria volunteer may miss the opportunity to receive treatment for dehydration, or to be referred to a health facility for antibiotics when they have pneumonia.

Activities to upgrade the skills of community-based providers should incorporate the principles that underlie clinical IMCI, such as classification and treatment of all the problems a sick child has, not just the presenting complaint. Activities should also take into account:

- Incentives for community-based providers to become involved in these training activities, such as improvement in business, prestige or better outcomes for sick children;
- Disincentives for providers to become involved such as spending time away from the business during training, less ability to respond to community demand for services such as injections;
- The level of formal training and literacy of the providers; even simplified diagnostic and treatment algorithms may be too complex in many cases;
- Local regulations regarding the distribution and sale of antibiotics and other drugs; in some settings young children can be treated with an antimalarial or antibiotic in the community, while in other cases the community-based provider should refer the child to a health facility for treatment; and
- The length of time a training course can last; in many cases providers are unwilling to attend courses lasting more than one or two days, which considerably limits the scope of the training.

Just as the clinical IMCI algorithms incorporate previous algorithms developed by disease-specific control programs for the diagnosis and treatment of ARI, diarrhea and malaria, community IMCI needs to incorporate previous experience with interventions to improve treatment of sick children in the community.

Simplified treatment algorithms and training courses in how to use the simplified algorithms have already been developed. The BASICS Project and World Education developed a 12-day course for health workers with low levels of literacy, such as health auxiliaries.

The following examples demonstrate approaches taken by NGOs to upgrade the skills of community-based providers in two different settings.

- The program described in the first example demonstrates an approach for training a new cadre of health workers: community health workers (CHWs) recruited by projects. The "Community Management of Childhood Illness" approach pioneered by CARE in Nyanza Province, Kenya adapted algorithms for use by community health workers, and is receiving much attention. It may be a model for other programs in Africa.

- The second example, in contrast, describes the training of existing providers working in the informal sector in Uganda; traditional healers and drug sellers.

The Community Initiatives For Child Survival Project, Siaya, Kenya

(The material for this example is from the Report of The International Workshop on Improving Children's Health and Nutrition in Communities, Durban, June 20-23, 2000)

In 1995, CARE Kenya and the Ministry of Health began implementing the Community Initiatives for Child Survival Project in Siaya district, Nyanza province, with the support of USAID and the US Centers for Disease Control and Prevention. By developing the skills of community-based health workers, the project seeks to reduce childhood illness and death from the three most common causes: malaria, pneumonia and diarrhea. Trained community health workers provide vital access to quality, affordable health care for children in their communities. Charts and training materials were adapted for community health workers, based on IMCI guidelines for managing cough or difficult breathing, fever and diarrhea; and for counseling mothers on home care, when to return to the community heath worker for care, and when to take the child promptly to the clinic.

Since 1997, 350 community health workers—two volunteers for each village—have been trained in a 15-day course. Of these, 290 (86 percent) are still active. To maintain their skills, they regularly participate in assessment and skill building sessions in the health facility, where the CARE extension workers and health facility staff supervise them. In addition, every two years the clinical proficiency of a sample of workers is assessed, and the results shape additional refresher training.

Using the approach promoted through the Bamako Initiative, community pharmacies have been established to provide greater access to drugs and insecticide-treated bednets. The Ministry of Health authorized community health workers to dispense cotrimoxazole for treating children with pneumonia and sulphadoxine–pyrimethamine for malaria. This authorization, given as yet only to community workers trained by CARE, has been a major breakthrough that may lead to broader policy changes.

Community health workers also promote immunization, the use of bednets, and use of more nutritional foods. They also give therapeutic dosages of vitamin A supplements. The Ministry contributes technical support and helps to monitor these child survival activities. Observations of a sample of trained community health workers in 1998, and again in 1999, identified their skills in assessing and treating sick children. The rate of correct treatment with drugs remained high for the two years following training. Community health workers were less able to identify and refer children who were severely ill. This information was used to develop refresher courses that emphasized recognition of the signs indicating urgent referral.

Year	1999	1998
No. cases observed	100	108
Indicator of quality		
Severe illnesses treated with the correct drug	78%	76%
Moderate illnesses treated with the correct drug	65%	74%
Children with severe illness referred	55%	13%

Partnering with Traditional Healers and Drug Sellers in Uganda (*34*)

Minnesota International Health Volunteers (MIHV) has worked closely with both traditional providers of health services (TBAs, traditional healers, and drug shopkeepers), and parents in the improvement of home management of sick children in Ssembabule District, Uganda. They have focused on the two most common causes of illness in children under five years—malaria and diarrheal disease. MIHV's baseline KPC survey showed that approximately 80 percent of mothers access health care through TBAs, traditional healers, and drug shopkeepers first, using MOH health facilities primarily for emergency situations. In part, this is because the district is very remote, with limited health infrastructure. To reduce child morbidity and mortality from these diseases the project employed a successful BCC strategy.

MIHV produced 2,500 calendars for the year 2000 with age-appropriate malaria treatment and diarrheal disease prevention messages. The calendars were widely distributed throughout the community, increasing household access to critical information. MIHV trained 50 women's groups and 2,000 community volunteers on proper home management of these illnesses to reinforce these messages. MIHV trained drug shopkeepers in the proper provision of chloroquine to their customers, and discouraged them from selling antibiotics for diarrheal disease treatment. MIHV followed up with quarterly monitoring visits to review shop records of patients treated and dosages given. MIHV trained traditional healers in proper treatment and referral for malaria and diarrheal disease, and developed a working referral system with the MOH facility staff. The project succeeded by emphasizing and supporting focused messages with all stakeholders in the system.

V.3 Activity #2: Engage Community-based Providers in the Promotion of Prevention, Nutrition, and Development

Community health workers and other classes of voluntary workers have been used for many years to promote preventive practices in the community. HH/C IMCI seeks ways to improve the quality of the preventive services they deliver, and to expand the range of services they offer to include promotion of a wider range of practices related to prevention, nutrition and mental development.

Relatively few programs have engaged the various classes of private providers in promotion of preventive interventions. One notable exception has been the programs that have trained traditional practitioners in Africa to promote HIV/AIDS prevention methods including condoms (*53-56*). These programs have been successful in part because many people seek care from traditional practitioners for sexually-transmitted diseases. HH/C IMCI challenges programs to find new ways to engage private providers in the promotion of preventive interventions.

V.4 Activity #3: Institute Systems to Improve Referral of Patients and Communication Between Households, Community-based and Facility-based Providers

Regardless of what is done to improve home management of sick children and improve the skills of community-based providers, many sick children will require referral to a higher level of care. Two types of referral can be considered:

- Referral from a community-based provider (traditional healer or midwife, community health worker, pharmacist, shopkeeper or physician in private practice) to a health facility; and

- Referral from a health facility offering limited care (health post with no beds, staffed by a nursing aide) to a facility offering more comprehensive care (dispensary or hospital with inpatient beds and ability to administer intravenous fluids and drugs).

The first type of referral clearly falls within the scope of HH/C IMCI, while the second type is part of all three components of IMCI: the first component (upgrading health workers skills: recognizing which children require referral), the second component (health systems: establishing and maintaining a system of facilities offering different levels of care) and the third component (role of the community in facilitating transfer of sick children from one facility to another).

The basic elements of a functional referral system include:

- Fully equipped and appropriately staffed referral facilities;
- Transport to the referral facility;
- Communication about the child being referred (referral slips, radio calls);
- Feedback from the referral facility to the provider who made the referral; and
- Removal of economic barriers to referral, for example by waiving user fees when children are referred to a second facility.

HH/C IMCI activities may include organization of a community-based system of emergency transport for sick children (and obstetric emergencies), education of community-based providers regarding conditions that require referral, and facilities that provide higher level care, and institution of a system of referral slips (*57-60*). Recent research in Imbabura, Ecuador conducted as part of a WHO multi-country study on referral suggests that using referral slips, rather than simply making a verbal referral, not only provides valuable information to the referral facility about the child's medical history, but also makes the caretakers more likely to comply with referral (to take the child to the referral facility as instructed by the health worker making the referral) (*61*).

Linking health facilities with communities in rural Peru (*62*)

The ENLACE child survival project was implemented in the provinces of Otuzco and Julcán in rural northern Peru from 1996 to 2000 by a partnership of the Ministry of Health, CARE International and Community Health Promoter Associations (CHPAs). A key strategy of the project was to strengthen the CHPAs and link them to health facilities at the peripheral level and to communities. The strategy included fundraising and support of health promoter needs by the Ministry of Health. The project implemented a community-based health surveillance system (CBHSS) that comprised 1) a community-based information system that recorded scheduled monthly visits by health promoters and vital events, 2) a community-to-facility patient referral and counter-referral protocol, and 3) a protocol for the emergency evacuation of sick patients including stretchers, radio transmitters, and family savings schemes. Referral and counter-referral cards for patients contain illustrations for easy use by community health promoters. This instrument consists of three cards: one for monitoring by the promoter, the second for control by the health facility, and the third for counter-referrals.

V.5 Activity #4: Ensure Supply of Essential First-Line Drugs at the Community Level: Drug Revolving Funds, Community Pharmacies

This is one of several activities related to improving health systems at the community level. Such activities could be thought of as part of the second component of IMCI, improving health systems, or as part of HH/C IMCI, as shown in the following table.

Table 6. Improving Health Worker Skills and Health Systems in IMCI

Site	Improving the skills of health workers	Improving the health system
Health facility	IMCI Component #1: Improving the skills of doctors and nurses	IMCI Component #2
Community	HH/C Element #2: Improving the skills of Community Health Workers, traditional healers etc.	IMCI Component #2 or HH/C IMCI Element #2

A program may decide to make essential drugs available outside of public health facilities and pharmacies. This should be done in consultation with the different partners involved in child health activities in the country. Managers can also consider other ways that lack of access to essential medications could be addressed. Any effort to improve the supply of drugs at the community level ideally would be directly linked to efforts to improve the supply in health facilities, and might therefore be part of the second component of IMCI. There may be situations where supplying drugs to health facilities and to the community level are separate processes that may not be linked at all, and that addressing supply at the community levels fits better within HH/C IMCI.

Regardless of whether this activity is part of the second component of IMCI or part of HH/C IMCI, the functioning of existing systems to supply medications to health facilities, the private sector and community groups such as Bamako Initiative pharmacies (*63-65*) will need to be evaluated. The need for additional mechanisms for distribution of drugs should be carefully

assessed. Community-based providers may already have access to drugs, but they are frequently mislabeled, adulterated or expired. The following example, which describes the experiences of Save the Children in Bougouni, Mali, illustrates a system set up to make basic drugs available in villages without a public health facility. While this was not technically an IMCI program, the system set up is critical to the success of HH/C IMCI activities that attempt to improve the treatment of sick children outside of health facilities.

Village Drug Kits (caisses pharmaceutiques) in Bougouni District, Mali

At the beginning of Save the Children's Child Survival XI Project in Bougouni District, Mali, essential drugs were not available at the village level. This was most noticeable for malaria, as chloroquine was completely unavailable in many villages. Village drug kits (caisses pharmaceutiques) were established in villages with a functioning Village Health Committee (CVS). Villagers had to pay for all products, although some allowance was made for drugs to be purchased on credit, particularly malaria drugs during the rainy season. The basic set of seven products that were stocked in each kit were: oral rehydration solution sachets, Nivaquine (chloroquine) syrup, Nivaquine (chloroquine) tablets, paracetamol, alcohol, Band-aids, and Aureomycin (tetracycline) drops.

The steps followed in establishing a village drug kit were: 1) Carry out literacy training for the members of the Village Health Committee; 2) Select two managers for each village drug kit; 3) Select the site of the village drug kit—often the home of one of the managers; 4) Provide training to the managers on how to prescribe the drugs; and 5) Provide training in managing the revolving drug fund. The treatment of malaria with chloroquine (Nivaquine) and diarrhea with ORS received particular emphasis. Managers were taught, for example, the dosage of chloroquine appropriate for different age groups, and how to explain to the mother how the child should take the drug.

One year after establishment of the village drug kits, oral contraceptives and condoms were added to the products included in the kits. The village drug kits have been extremely effective in making essential drugs available at the village level. A total of 118 kits were established in the project area, of which 90 percent were estimated to be functioning well. Although the medications were dispensed outside of a public health facility, usually from a private home, the system was supervised jointly by village health committees and government-run community health centers.

V.6 Activity #5: Decrease Harmful Practices Associated With Treatment Outside of Health Facilities

(Unsafe injections, treatments unsafe for children, overuse and underdosing of antimicrobials favoring emergence of drug resistant microorganisms)

The previous activities are part of a broader objective to treat sick children early with an effective treatment. The emphasis is on reducing morbidity and mortality from the presenting diseases. This activity focuses on adverse effects associated with inappropriate treatment in the community. Of particular concern are transmission of blood-borne diseases such as Hepatitis B, Hepatitis C and HIV through unsafe injections (*66-68*), promotion of drug-resistant microorganisms through overuse and underdosing of antimicrobials (*69, 70*), and treatment with drugs not recommended for routine use in young children such as tetracycline, chloramphenicol

and purgatives for diarrhea. In many countries people already have needles and syringes in the home that they use for treating family members and perceive to be safer than needles found in health facilities, and children are already being treated with unsafe drugs (*71*). HH/C IMCI programs need to address this situation by, for example, increasing the awareness of providers and community members of the risks associated with these practices and promotion of compliance with a full course of antimicrobial treatment.

V.7 Activity #6: Sustaining Community-based Provider Programs

Programs to recruit and train or improve the skills of community-based providers have been notoriously difficult to sustain for two reasons:

- Attrition or turnover: The providers who have been trained cease working, leave the area and/or move on to another job. This is a particular problem with cadres of providers such as community health workers who were not previously working in health, but were recruited and trained by the program; or

- Failure to maintain quality of care: The providers who have been trained continue working, but no longer apply the diagnostic and treatment practices that were taught by the training. This situation is encountered with all training programs for health workers. It is, however, a particular problem for cadres of providers such as traditional healers and ambulatory drug vendors who had an established style of practice often very different from that advocated in IMCI guidelines and policies, as well as a customer base that appreciates this style of practice. Factors favoring reversion to previous practices include economic incentives to provide more profitable treatments and services (e.g. antidiarrheal drugs instead of oral rehydration solution), and consumer demand for injections of "stronger" antibiotics (chloramphenicol, gentamycin).

These reasons have been well-documented for many years. Two of the best reviews of the various issues involved in sustaining these programs were published in 1979 and 1982 by the American Public Health Association (*72, 73*). Specific steps to implement this activity include:

- *Development of sustainable systems of incentives:* Suitable incentives are required to maintain community health workers and other types of providers in their posts. Monetary incentives are generally more effective initially if combined with intrinsic incentives such as recognition, but difficult to sustain once external funding ends.

- *Adaptation of performance maintenance methods:* Systems for maintaining performance and skills have been applied to facility-based workers. To apply them outside of facilities requires considerable adaptation, especially when providers are not employees of the Ministry of Health or of the project (*74*).

It should be pointed out that some program managers view attrition as an opportunity rather than a problem. Volunteers are viewed as graduates who will promote healthy behaviors among their family and peers after leaving the program. The emphasis may therefore be put on making recruitment and training of new volunteers more efficient.

Optimizing incentives for community volunteers in El Salvador (*75*)

Catholic Relief Services (CRS) and CARITAS implemented a Child Survival Project in three departments of El Salvador's Eastern/Paracentral region from 1995 to 2000. The program set up Community Health Committees and recruited and trained two classes of voluntary worker: health collaborators who make home visits and conduct health education, and health promoters who maintained the health information systems and supervised the health collaborators. After the mid-term evaluation in 1997 showed an attrition rate of 31 percent among the volunteers, the program designed and implemented a multi-incentive plan based on the Pareek motivational model (*76*) that addressed six aspects of motivation: achievement, affiliation, extension, influence, control and dependency. After implementation, two of the three project communities demonstrated lower rates of attrition, while a third demonstrated high rates due to the establishment of a garment factory. Many of the volunteers living in the vicinity of the new factory apparently were attracted to apply to work there, and subsequently ceased working as volunteers. Key factors at the community level promoting retention of volunteers were community recognition, gear that identified them as volunteers, preferential treatment, clear roles and expectations, and volunteer networks.

Freedom From Hunger's system of field agent-centered management (*74*)

Freedom From Hunger has developed a system for recruiting, training and supervising field supervisors. The resulting good supervision or "support-vision" steers field agent performance toward program objectives. The term "support-vision" indicates that the purpose of supervisory visits is to provide support, encouragement and constructive feedback on performance rather than to find fault or admonish. Field staff-centered management has two major components: signaling and support. Clear and consistent signals are given by supervisors to field staff about what good field staff are expected to do and how valuable they are to the program when they do it well. The program is structured to enable the supervisor to provide the field staff with adequate and timely support to do their jobs well.

V.8 Relationship to the First Two Components of IMCI

This Element of the Framework has a complex relationship with the first two components of IMCI, improving the skills of health workers and improving health systems. On one hand, the rationale for many of the activities carried out within this Element in the Framework is to improve the care of sick children where public health facilities and government health workers are absent or too few in number to adequately care for all of the sick children, or where the public health system fails to function for any of a variety of other financial and administrative reasons. On the other hand, there are clear limits to what can be done for sick children outside of health facilities. Ideally the first two components of IMCI will be in place so that severely ill children can be referred when diagnostic difficulties or the need for advanced monitoring and treatment mean that there is limited, if any, benefit to the care provided at the household and community levels.

Implementation of the first two components of IMCI can also make an important contribution to the sustainability of activities related to this programmatic Element. Any system to improve care given to children outside of health facilities will cease to function unless there is some sort of supervision and regular feedback to community members, community health

workers and other community-based providers. A logical group to carry out this supervision is facility-based health workers who have received IMCI training. IMCI training provides them with criteria to evaluate whether care given outside health facilities is being done adequately, and gives them a broader base of knowledge that they can draw upon during supervision.

V.9 How Element 2 Differs From Previous Primary Health Care Programs

Training of voluntary workers as well as providers in the traditional and private sectors has been part of primary health care programs for many years (*72, 73*). The second Element of the HH/C IMCI Framework differs from these previous programs in its attempt to apply IMCI concepts and standards of care to this work, in its increased focus on private providers, and in the development of courses and other interventions to improve quality of care that are integrated rather than disease specific. Examples of IMCI concepts and tools that are adapted for use in the home and community include treatment of all conditions a child has, and the use of algorithms for making decisions about the management of sick children.

V.10 Innovative NGO Approaches to the Implementation of This Element

NGOs have long played a role in improving the care sick children receive outside of public health facilities. Specifically they have extensive experience with issues related to the recruitment, training and retention of community health workers, promotion of home treatment of diarrhea and other diseases, and establishment of drug revolving funds and community pharmacies. Their history of collaboration with networks of CHWs make them key partners in development and testing of new approaches to improving the skills and sustainability of community-based providers, as well as health auxiliaries who conduct community outreach. NGOs have also piloted approaches to working with traditional healers and drug sellers.

VI. ELEMENT THREE: Integrated Promotion of Key Family Practices Critical for Child Health and Nutrition

Promotion of practices critical for child health and nutrition is not a new activity for MOHs, PVOs and NGOs. It has long been the cornerstone of child health programs. The task facing HH/C IMCI is not how to implement single interventions or program components such as ORT promotion, immunization or promotion of exclusive breastfeeding, but how a program can promote a whole range of key family practices without sacrificing the effectiveness characteristic of the single-intervention-focused programs. How can a program promote five, ten or even fifteen practices in an effective way? This programmatic Element is particularly important where there has been previous success with promotion of single interventions or program components (immunization, ORT, growth monitoring, etc.). Lack of coordination between these different interventions in either their planning or their implementation may lead to long-term loss of effectiveness or contribute to a lack of sustainability. Implementation of this Element should include coordinated and strategic use of the mass media through national and regional channels of communication linked closely with behavior change efforts at the district and community levels.

VI.1 Key Family Practices and Emphasis Behaviors

At the core of this Element are a set of practices that an HH/C IMCI program aims to promote, such as handwashing, breastfeeding, and regular use and retreatment of mosquito nets. From the perspective of specialists in behavior change interventions, these "practices" or "behaviors" are really behavioral objectives in many cases, rather than specific behaviors that a program would promote as stated. Many of them imply a series of sub-behaviors or more specific behaviors that should be defined at the program level by combining the latest scientific information on efficacy with in-depth input on acceptability and feasibility from those groups that are expected to carry out the specific practices. For example, the behavioral objective of having people sleep under insecticide-treated mosquito nets involves a large series of sub-behaviors including purchasing nets, purchasing insecticide, applying the insecticide correctly to the net, washing the net less frequently so that the insecticide maintains its potency, hanging the net over the bed correctly, and sleeping under the net throughout the year in areas of endemic transmission.

As an aid to planning of HH/C IMCI programs, WHO and UNICEF developed "The Key Family Practices," while the BASICS I Project developed the Emphasis Behavior approach, each consisting of 16 "practices" or "behaviors." The two lists are complementary, and each provide different kinds of information. Program managers can benefit from looking at both lists. The lists differ in two ways:

- Some practices or behaviors are on one list, but not the other. For example, care for HIV-infected people including orphans is on the list of Key Family Practices, but not on the list of Emphasis Behaviors; and
- The same practices and behaviors are sometimes defined in different ways on the two lists. The list of Key Family Practices recommends that pregnant women have at least four antenatal visits, while the list of Emphasis Behaviors recommends at least two antenatal visits.

Key Family Practices. Although previously there have been 12 Key Family Practices, at the Durban meeting in June 2000, consensus was reached on a list of 16 key family practices, as shown in Table 7 (*3*). This list of "practices" (behavioral objectives) has now been divided into four groups:

- Practices for physical growth and mental development
- Practices for disease prevention,
- Practices for appropriate home care, and
- Practices for seeking care.

There has been considerable input into this list at different workshops and meetings where participants have been challenged to develop a vision for improving practices at the household and community levels (*3, 24*). The outcome of this process is a list that summarizes in a powerful way not only where child health and nutrition programs are now, but also directions they can move in the future.

- Exclusive breastfeeding, provision of micronutrients and taking children for immunization are examples of practices that programs are already promoting. The technical interventions and indicators to measure impact are well defined.

- Promotion of mental and social development, care of HIV/AIDS, prevention of child abuse and neglect, and ensuring the participation of men are examples of practices that have often not been included in child survival programs in the past. Including these practices in the list challenges the different actors involved in child health and nutrition to examine other dimensions of well-being among young children, and invest time and effort in developing new intervention strategies.

Emphasis behaviors. The list of 16 Emphasis Behaviors in Maternal and Child Health were developed by the USAID-funded BASICS I Project, and are shown in Table 8 (*77*). The "behaviors" or behavioral objectives were selected based on existing epidemiological data on the major causes of mortality and morbidity among young children, and evidence for the effectiveness of the child survival interventions such as measles immunization, vitamin A supplementation and insecticide-treated bed nets. For problems where little good epidemiological data exist, or there is insufficient evidence for the effectiveness of interventions, no Emphasis Behaviors were defined.

From the perspective of a program manager, the list of Emphasis Behaviors has several strengths:

- The impact of achieving each of the behavioral objectives on mortality and morbidity has been demonstrated.
- Questions for household surveys and indicators have been defined for each behavior.
- The Emphasis Behavior document is available in English, French, and Portuguese. A Spanish version is in preparation.
- Good documentation on the behaviors is available at the BASICS website at http://www.basics.org/publications/Emphasis/Emphasis.htm.

Table 7. List of Key Family Practices Adopted by WHO and UNICEF (*3*)

(List presented at The International Workshop on Improving Children's Health and Nutrition in Communities, Durban, June 20-23, 2000)

For physical growth and mental development

- Breastfeed infants exclusively for at least four months and, if possible, up to six months. (Mothers found to be HIV positive require counseling about possible alternatives to breastfeeding.)
- Starting at about six months of age, feed children freshly prepared energy and nutrient-rich complementary foods, while continuing to breastfeed up to two years or longer.
- Ensure that children receive adequate amounts of micronutrients (vitamin A and iron, in particular), either in their diet or through supplementation.
- Promote mental and social development by responding to a child's needs for care, through talking, playing, and providing a stimulating environment.

For disease prevention

- Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday.
- Dispose of feces, including children's feces, safely; and wash hands after defecation, before preparing meals, and before feeding children.
- Protect children in malaria-endemic areas, by ensuring that they sleep under insecticide-treated bednets.
- Adopt and sustain appropriate behavior regarding prevention and care for HIV/AIDS affected people, including orphans.

For appropriate home care

- Continue to feed and offer more fluids, including breastmilk, to children when they are sick.
- Give sick children appropriate home treatment for infections.
- Take appropriate actions to prevent and manage child injuries and accidents.
- Prevent child abuse and neglect, and take appropriate action when it has occurred.
- Ensure that men actively participate in providing childcare, and are involved in the reproductive health of the family.

For seeking care

- Recognize when sick children need treatment outside the home and seek care from appropriate providers.
- Follow the health worker's advice about treatment, follow-up and referral.
- Ensure that every pregnant woman has adequate antenatal care. This includes having at least four antenatal visits with an appropriate health care provider, and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

Table 8. List of BASICS Emphasis Behaviors (*77*)

REPRODUCTIVE HEALTH PRACTICES: *Women of reproductive age need to practice family planning and seek antenatal care when they are pregnant.*

1. For all women of reproductive age, delay the first pregnancy, practice birth spacing and limit family size.
2. For all pregnant women, seek antenatal care at least two times during the pregnancy.
3. For all pregnant women, take iron tablets.

INFANT AND CHILD FEEDING PRACTICES: *Mothers need to give age-appropriate foods and fluids.*

4. Breastfeed exclusively for about six months.
5. From about six months, provide appropriate complementary feeding and continue breastfeeding until 24 months.

IMMUNIZATION PRACTICES: *Infants need to receive a full course of vaccinations; women of childbearing age need to receive an appropriate course of tetanus vaccinations.*

6. Take infant for measles immunization as soon as possible after the age of nine months.
7. Take infant for immunization even when he or she is sick. Allow sick infant to be immunized during visit for curative care.
8. For pregnant women and women of childbearing age, seek tetanus toxoid vaccine at every opportunity.

HOME HEALTH PRACTICES: *Caretakers need to implement appropriate behaviors to prevent childhood illnesses and to treat them when they do occur.*

PREVENTION

9 Use and maintain insecticide-treated bednets.
10. Wash hands with soap at appropriate times.
11. For all infants and children over six months, consume enough vitamin A to prevent vitamin A deficiency.
12. For all families, use iodized salt.

TREATMENT

13. Continue feeding and increase fluids during illness; increase feeding after illness.
14. Mix and administer ORS, or appropriate home-available fluid, correctly.
15. Administer treatment and medications according to instruction (amount and duration).

CARE-SEEKING PRACTICES: *Caretakers need to recognize a sick infant or child and need to know when to take the infant or child to a health worker or health facility.*

16. Seek appropriate care when infant or child is recognized as being sick (i.e., looks unwell, not playing, not eating or drinking, lethargic or change in consciousness, vomiting frequently, high fever, fast or difficult breathing).

Two principal activities related to the integrated promotion of key family practices are:

- Develop approaches for behavioral change and communication that effectively promote the full range of Key Family Practices or Emphasis Behaviors appropriate for any given setting, and
- Develop methods for participatory community assessment and planning that involve the community in the selection of behaviors to be promoted and identification of actions to be taken to promote the selected behaviors.

Table 9. A vision for the Integrated Promotion of the 16 Key Family Practices

Prior to implementation	After implementation
• Limited number of practices are promoted	• Most major practices for child health, nutrition and development are promoted
• Separate training courses, communication materials and manuals for promotion of each of the key family practices	• Integrated set of training courses, communication materials and manuals for promotion of the key family practices
• Promotion of the different practices occurs according to the administrative needs of the program, and does not take into consideration the perspective of the community	• Promotion of the different practices occurs according to the needs of the community, and takes into consideration community perspectives and capabilities
• National IEC program without coordination at the district level. Competing messages are put out by different organizations.	• Coordinated IEC strategy with prioritized messages using multiple channels from national to community level to support behavior change.
• Community has no role in selection of practices to be promoted, or in developing, implementing and evaluating activities to promote the practices	• Community has extensive role in selection of practices to be promoted, as well as in developing, implementing and evaluating activities to promote the practices

VI.2 Activity #1: Develop Integrated Behavior Change Strategies

Once integrated assessments or surveys have been conducted to measure the full range of household practices, program managers will consider what behavior change strategy to use to promote behaviors found to require further promotion. The methods of Behavior Change Communication (BCC) and social marketing have been successful in promoting behaviors and practices such as oral rehydration therapy for diarrhea, family planning and immunization at the national level, and are critical tools for the implementation of HH/C IMCI. BCC has been most successful with the programs promoting single behavioral objectives (e.g. ORT use) or clusters of closely-related behavioral objectives (e.g. family planning), and their effectiveness has been demonstrated. The major challenge for BCC in HH/C IMCI is how to promote several very different sets of behavioral objectives in one integrated package while maintaining the effectiveness of communication programs that promote single objectives. Promotion of packages of behavioral objectives frequently has limited impact relative to promotion of single objectives, for the following reasons:

- The details of how and when to perform each behavior, and the benefits to the mother/patient/customer of performing each one may be omitted in an integrated approach due to lack of time;
- The target audience for the intervention may get "information overload": too much said about too many different behaviors all at once;
- Program managers may find they don't have the time to carry out the formative research and intervention and materials development necessary for each individual behavioral objective when promoting many different objectives;
- Health workers or other change agents may be unable to effectively promote multiple behaviors when, for example, they are unable to remember the specific benefits to be promoted for each one; and
- The print materials and commodities needed to support the implementation may not be available or may not be in the right place at the right time.

BCC seeks to develop packages of behaviors that are client-centered, taking into account who is to perform the behaviors, and the time (dry season versus wet season, continuous versus periodic, pre-natal versus post-natal) and place (household, community, health facility) they are to be performed. The list of key family practices or emphasis behaviors could be formed into three or four groups. An example of such grouping is given below:

Table 10. Example of a More Client-centered Grouping of Key Behaviors

Periodic behaviors	Treatment-seeking and care of the sick child	Feeding, food preparation and water use	Safe environment
- Vaccination - Vitamin A - Growth monitoring - Pre/post natal visits - Treatment of mosquito nets with insecticide	- Illness recognition - Treatment in home - Care-seeking outside home - Administer drugs according to instructions	- Exclusive breastfeeding - Appropriate weaning practices - Hand-washing - Safe water storage	- Latrines/Feces disposal - Sleep under mosquito nets

Grouping promotion of behaviors in such a way cuts across the lines drawn by previous disease-specific programs. It moves HH/C IMCI away from being a series of superimposed vertical programs (CDD, ARI, nutrition, EPI, malaria) coexisting with each other in a new house to being one single integrated approach.

Another challenge to applying BCC principles to HH/C IMCI programs is learning how to deliver information in small doses. If all Key Family Practices or Emphasis Behaviors are promoted simultaneously, people will quickly get information overload, and the behavior change interventions will have little effectiveness.

Approaches for delivering information in small doses include:

- *Develop guided counseling materials for community educators*. Another approach that has been used in Indonesia (HealthCOM) (*78, 79*), Honduras (Atención Integral a la Niñez–AIN) and other programs has been to develop a cadre of community educators and counseling materials that guide them to tailoring the information and discussion with each individual mother to her and her child's situation—whether the child is growing adequately, is or has been sick, is or is not being breastfed, etc. This is supported by the use of mass media on general themes.

- *Use of mass media.* Use of mass media may in some cases decrease the amount of information that CHWs and other change agents need to pass on to people. Mass media can promote basic program themes and concepts; deflate obstacles of perceptions, attitudes and norms; help create the perception of new norms; and (last but not least) legitimize local health workers and volunteers as sources of reliable and useful information. Use of mass media to address general themes combined with tailored counseling to individual caretakers by community educators on specific themes is felt to be the best practice by many behavior change specialists.

- *Umbrella themes and subthemes*. It is standard communication practice, when there are many ideas or behaviors to promote, to develop an umbrella theme and then to phase in sub-themes gradually and logically (e.g. in the appropriate season) over time. Behaviors are promoted in a sequence, with the promotion of each new behavior building on the promotion of previous behaviors. One approach in several settings has been the "theme of the month," such as vitamin A or anemia.

- *Season-specific promotion of behaviors*. For any given country, integrated behavior change strategies are implemented according to a seasonal calendar which specifies the important times of the year for each behavior to be practiced, and when behavioral promotion needs to occur so that the key behaviors will be promoted at those times (*80, 81*).

Innovative approaches to promoting multiple behaviors in Nicaragua (*82*)

Project Concern International (PCI) implemented a Child Survival Project from 1994 to 1997 in several marginal urban areas of Managua, Nicaragua. The program focused on 16 behaviors in eight priority areas: immunization, diarrheal disease, respiratory illness, growth promotion and monitoring, nutrition and vitamin A, breastfeeding, maternal health and family planning. Health volunteers first underwent basic training, then were trained in how to integrate the messages so that mothers received more comprehensive information on maternal and child health. A key tool for integration of messages was the maternal-child health calendar. This simple instrument was provided to mothers to track important health events throughout each month. It served not only to increase caretaker awareness and health practices, but also was a didactic tool that health volunteers (brigadistas) could use during home visits.

Review of behavior change approaches by CORE

The CORE Behavior Change Communications group has recently conducted a comprehensive review of behavior change theories and approaches, and their application in NGO health programs. This is a valuable tool for program managers thinking about how to promote behavior change in the community. The report, entitled "Health Education in Primary Health Care Projects: A Critical Review of Various Approaches" can be downloaded at: http://www.coregroup.org/publications_files.cfm.

VI.3 Activity #2: Develop Methods for Participatory Community Assessment and Planning

This activity is part of all three programmatic Elements, but it is discussed here because of its relevance to the selection of behaviors/practices to be promoted within a program. Advocates of participatory assessment and planning argue that if HH/C IMCI is to be effective and sustainable, communities need to be empowered to take responsibility for their own health. For HH/C IMCI, this means that communities develop a sense of ownership over the key practices, and assume the responsibility for practicing and promoting them over the long term. Participatory research methods are important tools for communities to learn about and assume responsibility for these behaviors.

One example of participatory assessment and planning as an entry point is a methodology developed by the BASICS I project and tested in Zambia, Ethiopia and Morocco (*83*). The process consists of the following four phases, with Phases 2, 3 and 4 implemented over a period of about two weeks:

- *Phase 1: Building Partnerships:* The goal of this phase is to establish working relationships between health staff and community team members.
- *Phase 2: Selecting the Emphasis Behaviors:* A simple household survey is carried out to collect information on the key maternal and child health behaviors in a sample of households. The behaviors shown to be at unacceptable levels are ranked and three to five priority behaviors are selected.
- *Phase 3: Exploring Reasons for the Behaviors*: A variety of participatory research techniques, including semi-structured interviews, seasonal calendars, and matrix ranking/scoring, are used to explore the reasons behind the practices of the three to five selected behaviors.
- *Phase 4: Developing Intervention Strategies*: Interviews are developed based on the reasons people were or were not doing the selected behaviors. Intervention strategies are suggested by community members and the health staff, and a plan for implementing strategies is developed. The action plan includes identification of resource needs and allocation of responsibilities.

The following are two examples of programs where communities have been actively involved in selecting the behaviors to be promoted and the approach used to promote them. The first example is from the World Vision Bergville Child Survival Project, while the second is from Morocco's IMCI program.

Participatory Learning and Action in South Africa (*84*)

The Participatory Learning and Action (PLA) method was the strategy chosen by the World Vision Bergville Child Survival Project to integrate communities into the health development process in the belief that the rural poor have a capacity to inform, learn and implement change. It is consistent with one of the key elements of the proposed National Health Plan, "to foster community participation across the health sector." The PLA moves from community appraisal and research to development, action and implementation. Secondly, the learning empowers the rural people to carry out exercises and to present the information themselves. Literally, the Bergville district health workers handed over the "stick" (of authority) to the community for them to lead the process. Lastly, unless one participates in the PLA process, it is impossible to have full knowledge of the community situation.

The PLA process was conducted in many of the 60 communities of the project area. The supervisor of one PLA team, a nurse who had practiced in Bergville for over twenty-five years remarked, "It is only now through the PLA that I am getting to know the communities in my home district for the first time." The teams met with community members in their village/community to conduct exercises resulting in: (1) a general map of the village, (2) identification of the health problems of women, children, youth and the disabled, (3) assessment of organizations existing in the village, (4) identification and use of local health care resources to address identified problems, (5) determination of sources of income, (6) selection of a Community Health Committee and Community Health Worker.

At the end of the two-day PLA, a DOH nursing supervisor remarked, "I have gained respect for the people and their knowledge of their community." Copies of all the proceedings were presented to the village headman and dates planned for an immunization campaign. Other outcomes of the PLA exercise included requests for Health Education Days on drug abuse, teenage pregnancy and HIV/AIDS. Also health messages drawn from the communities' own words were designed. Some of the creative health messages were, "Down with the bottle, up with the breast," "Love is great, but sex can wait," and, "Too many children, too much responsibility."

Participatory Community Assessment and Planning in Morocco (*85*)

IMCI was initially adopted in Morocco at the end of 1997. All three components were introduced almost simultaneously. Community Assessment and Planning exercises were conducted in three communities to study (in a participatory manner) the negative and positive impact of community practices on child morbidity and mortality. This was followed by

- An anthropological study of family and community perceptions and practices in the field of child health,
- Implementation of community action plans in collaboration with local NGOs, focusing on priority behavioral changes as identified by the communities themselves (such as an emergency transfer mechanism in one community, and literacy classes incorporating health education messages in others),
- Development of training materials and training of health center staff in both pilot provinces on the IMCI community approach and training of NGOs in IEC messages, and
- Production of a child health booklet as a continuity of care instrument, to be kept by the mother.

The HH/C IMCI approach has increased awareness by health managers and care providers of the need for family and community participation. An in-depth analysis to assess the impact and feasibility of this approach is planned after further implementation experience is gained.

The Positive Deviance approach

Another approach to community assessment and planning is the Positive Deviance (PD) approach (*86*). The observation which alerted people to the potential for this approach is that in communities where everyone faces serious resource limitations, some families nevertheless find a way to keep their children healthy and well nourished. The "Positive Deviance" (PD) approach is based on the premise that solutions to community problems already exist within the community. Through a Positive Deviance inquiry, program staff and community members identify the unique (uncommonly good) practices of some community members that set them apart from their peers, allowing them to cope more successfully within the same resource base. Once the practices are identified, staff and community develop strategies together to enable all members of the community not only to learn about these practices, but also to adopt them. PD has been used predominantly in nutrition to identify successful household level feeding, caring, and health seeking practices that contribute to child growth and well-being.

In communities where everyone has access to similar types and amounts of food, why are some children well-nourished and others under-nourished? The positive deviants are those households where children are well-nourished; they have deviated from the normal in a positive way. The community participates in identifying the positive deviants and learning how they keep their children well-nourished. The positive deviants then serve as a resource for families with malnourished children, sharing with them their methods of food preparation and feeding. Positive Deviance was first defined by the nutrition field as "adaptive responses for satisfactory child growth under harsh economic circumstances such as food scarcity." However, PD is increasingly being successfully applied to other behaviors, for example, increasing pregnancy weight gain, increasing consistent and correct use of condoms by commercial sex workers, and mobilizing communities against female genital cutting. The PD approach can potentially be used as a framework for implementation of the entire range of key practices, because households that are positive deviants for one behavior are frequently positive deviants for other behaviors. Positive deviants, once identified, may become resource people for the implementation of all of HH/C IMCI.

Using the "Positive Deviance" (PD) approach in Vietnam as part of a "HEARTH" program, more than 250 communities in collaboration with Save the Children rehabilitated an estimated 50,000 malnourished children from 1991–1999 using local resources (*86, 87*). The HEARTH Program consists of:

- Identification of successful behaviors among PD families through a Positive Deviance inquiry.
- Monthly, or every other month, weighing of all children in the target group through a growth monitoring and promotion activity.
- Monthly nutrition education and rehabilitation sessions for identified malnourished children and their caretakers in local kitchens run by community members.
- Community management of the HEARTH Nutrition Program through monthly, or every other month, Village Health Committee meetings.

- Vital Events Monitoring.

PD practices identified in Vietnam included the addition of shrimps/crabs and greens to a child's diet, increased frequency of feeding, good hygiene, and timely healthseeking behavior. In the program communities, moderate and severe malnutrition in children under the age of three was reduced by an estimated 55 to 85 percent. Of even greater significance, their younger siblings, many of whom were not yet born at the time of the nutrition program implementation, are benefiting from the same levels of enhanced nutritional status. Simply stated, Positive Deviance provided a tool for radically changing the conventional wisdom regarding nutrition and child caring practices in these communities. Numerous NGOs are successfully using the PD methodology as part of a nutritional rehabilitation program, HEARTH, in over 20 countries (*86, 87*).

VI.4 Integrated Assessments/Surveys to Measure Household Practices

Comprehensive assessments of community practices are a common first step in the implementation of the third Element in the HH/C IMCI framework. Without this information, rational program planning can be difficult. The main method being used for these comprehensive assessments are household surveys, including:

- The Multiple Indicator Cluster Survey (MICS) of UNICEF;
- The Integrated Household Assessment Questionnaire of UNICEF, which was first developed and used in seven districts in Tanzania (*88*);
- The KPC 2000+ survey developed by the CORE Group and the ORC Macro Child Survival Technical Support (CSTS) Project (*89*).

The latter is the principal tool used by NGOs in USAID-funded child survival programs. The KPC 2000+ is the product of a number of years of development. In response to the need for a rapid, easy to use means of assessing progress of child survival programs, USAID initially solicited help from the Child Survival Support Program (CSSP) of Johns Hopkins University. CSSP collaborated with NGO staff and designed the "Rapid Knowledge, Practices, and Coverage (KPC) Survey" for mothers of children under the age of two years. The KPC is a management tool that yields a concise and manageable set of indicators to monitor and estimate the results of NGO CS activities while fostering local participation in identifying health priorities and in monitoring community health status. In 1999, the Monitoring and Evaluation Working Group of the CORE Group collaborated with the Child Survival Technical Support Project (CSTS) based out of ORC Macro to expand the scope of the KPC survey to include other issues of programmatic importance, including anthropomentry, malaria, and HIV/STIs. The revised survey, the KPC2000, included freestanding modules and was distributed in December 1999. Over the past year, the KPC2000 was field tested by a number of PVOs. The latest version, the KPC 2000+, includes new and updated modules, as well as the Rapid CATCH (Core Assessment Tool on Child Health). There is also a Tabulation Plan for calculating key child health indicators. Specific KPC 2000+ modules can be downloaded in either Adobe Acrobat (PDF), WordPerfect (WP) or MS-Word formats at the CSTS Project website: www.childsurvival.com (*89*).

VI.5 Choosing One or More Entry Points for Implementation of Element #3

Integration of approaches and interventions is perhaps the key characteristic of HH/C IMCI. However, given the difficulty of initiating promotion of all Key Family Practices or Emphasis Behaviors simultaneously, many programs are choosing to start with the implementation of a single program component such as childhood immunization or nutrition, and building up to the promotion of a broader set of behaviors/practices. Depending on the program component selected, the promotion of one practice, or a package of related practices may be required. The differences between starting implementation of HH/C IMCI with a single program component such as childhood immunization, and a traditional vertically-organized single-component program are:

- The component for initial implementation is chosen strategically and if possible will be a priority for both community members and various partners in implementation; and
- When implemented as part of an HH/C IMCI program, the intention from the outset is to add other program components at a later date. This is explained to communities and partner organizations during initial planning;
- More effort is made to involve communities in planning and implementation, and to build community ownership over program activities;
- Implementation may involve the recruitment and training of community health workers, traditional healers, women's groups or other community partners who will continue to be involved when additional program components are implemented.

As might be expected, there is little agreement on what the first program activities to be implemented should be. Activities that are commonly nominated for initial implementation are:

Immunization: Arguments for making immunization the entry point include:

- It is a key activity that must be implemented sooner or later in any case;
- It generally has a high level of support both within governments and communities;
- It requires contact with all young children in a community, and therefore is a natural complement to other community mobilization activities;
- Nutrition activities that are periodic such as growth monitoring and Vitamin A distribution, and other periodic activities such as treatment of mosquito nets with insecticide, can be easily built onto routine immunization; and
- Some activities to improve treatment of sick children can be built onto routine immunization, as sick children are often brought to facilities when immunization is being offered.

Nutrition: Reasons for the selection of nutrition as an entry point include:

- Comprehensive nutrition programs require integrated promotion of very different behaviors and practices such as vitamin A supplementation, exclusive breastfeeding and appropriate weaning practices. Working out how to promote these practices in an integrated fashion provides a solid foundation for the subsequent integrated promotion of other practices unrelated to nutrition;
- A number of organizations have already developed integrated packages of nutrition interventions.

- By their very nature, nutrition interventions such as promotion of appropriate weaning foods require considerable negotiation with communities and mobilization of community-based providers, parents and community groups. This negotiation and mobilization forms a solid foundation for promotion of other practices, some of which have been promoted in a top-down manner by previous vertical programs.

Atención Integral a la Niñez (AIN) in Honduras is an example of a program that uses nutrition as an entry point for the promotion of a broad range of child health and nutrition practices. AIN is an integrated community health program that uses adequate growth of individual children and the entire community's children as an entry point to appropriate tailoring of health or nutrition actions, including individual counseling, home visits, treatment of illnesses, referral of sick children, and community actions in water and sanitation and other areas (*90*).

VI.6 How Element 3 Differs from Previous Primary Health Care Programs

The third Element of the HH/C Implementation Framework obviously represents an evolution rather than a revolution in programming at the community and household levels. The evolution of the approach as part of HH/C IMCI includes a more systematic approach to integrated promotion of different behaviors, better "support-a-vision" systems that combine signaling and support for field agents/volunteers, greater community input into the selection of behaviors to be promoted, and the introduction of innovative behavior change strategies such as Positive Deviance. Where IMCI has been implemented in health facilities, greater support is possible for all aspects of implementation at the community and household levels from the formal health system.

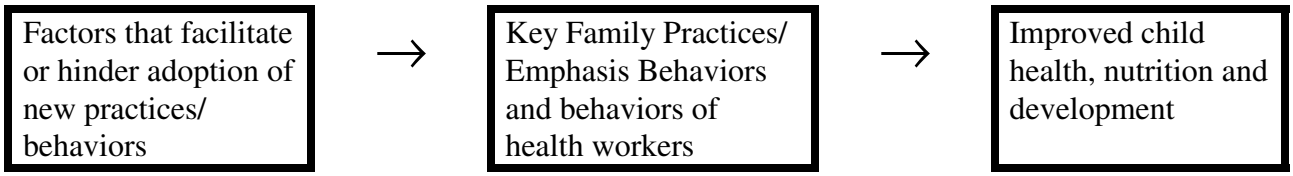
VI.7 Innovative NGO Approaches to the Implementation of This Element

While HH/C IMCI is a new term, the set of household practices *promoted within this programmatic Element* for HH/C IMCI have long been promoted by NGOs in their community-based health programs, including child survival projects. On the one hand it might appear that there is nothing new to HH/C IMCI, just a relabeling of what NGOs have long been doing. On the other hand, participation in HH/C IMCI demands that NGOs look at behavior change and community mobilization strategies in new ways, with an emphasis on integration and sustainability. This includes working with other NGOs and the Ministry of Health to develop common behavior change strategies at the national level that support activities at the local level. Some specific actions related to the third Element in the HH/C Framework are:

- Synthesize and systematize NGO experience in the promotion of packages of behaviors at the community level. This might include examining which program components are the best entry point for HH/C IMCI, or which behavior change interventions are most effective;
- Experiment with new approaches to integrated promotion of the entire range of key practices; and
- Introduce and disseminate innovative approaches to promotion of key practices at the community level, such as the Positive Deviance approach.

VII. The Multisectoral Platform for Improved Child Health, Nutrition, and Development

VII.1 Introduction



The three programmatic Elements all focus on specific behaviors and practices of parents of young children and health workers: CHWs, traditional healers, TBAs, private providers and facility-based health workers. The logic behind the Multisectoral Platform is that people may find it difficult or impossible to adopt new behaviors if other problems that they face, such as food insecurity or lack of access to clean water, are not also addressed. The Multisectoral Platform also provides an opportunity for NGOs and other organizations to work with local governments in decentralized systems to develop innovative approaches to promotion of child health, nutrition and development. At the national level, the Multisectoral Platform links the implementation of HH/C IMCI to health sector reform.

The Multisectoral Platform obviously has much in common with other strategies to promote economic and social development. The Platform differs from these other development strategies in one important respect: As part of HH/C IMCI strategy, efforts are made at all times to link development activities to specific Key Family Practices or Emphasis Behaviors:

- Improvements in water supply and sanitation need to be followed by promotion of hygiene behaviors such as hand-washing and safe water storage to ensure that the improvements in water supply and sanitation contribute to better child health;

- Agriculture-related projects that increase the quantity and variety of food available need to be linked to the promotion of appropriate weaning practices;

- Microenterprise and microcredit activities may be combined with the establishment of local funds or more formal health insurance schemes to which program participants contribute. These funds, or insurance schemes, could pay for cases of catastrophic illness or other unforeseen medical expenses;

- Microenterprise and microcredit programs encourage participants to invest some of the money they earn in health technologies such as insecticide-treated bednets;

- Economic development activities that succeed in actively involving men can be used as a starting point for promoting the involvement of men in reproductive health and the provision of childcare; and

- The introduction of new technologies and forms of employment needs to be linked to efforts to prevent child injuries and accidents.

The Multisectoral Platform focuses on innovative strategies for linking broader development activities with child health and nutrition. The example of a credit with education program demonstrates how an NGO in Ghana has made the link between social and economic development activities and promotion of specific health and nutrition behaviors. The word "optimize" is used in relation to the Multisectoral Platform to describe the search for appropriate ways to think and work beyond the health sector. This is not intended to be a rigid platform, but one that varies with the local context (needs and resources).

Credit with Education in Ghana (*91*)

Freedom from Hunger's "Credit with Education" program combines village bank services for women with non-formal education in breastfeeding, child nutrition, diarrhea control, immunization, and family planning. The joint delivery of services are expected to result in a) financial benefits for women through increase of personally controlled income and assets; b) psychological and social benefits for women through increased self-confidence and status within the family and community; and c) behavioral changes through increased knowledge and use of better health and nutrition practices.

The combination of credit with education is hypothesized to yield better household food security and improved personal nutritional status, particularly of the young children of a household. In Ghana, this hypothesis was born out. The nutritional status (height for age and weight for age scores) of one-year-old children of participating mothers showed significant and positive differences from baseline measures as compared to one-year-olds living in control communities. Participants were also exclusively breastfeeding longer and were more likely to know how to prevent and treat diarrhea. The program is well on its way to sustainability in that interest paid by the borrowers covered 81 percent of the rural banks' cost of delivering the credit and educating women within the first three years of the project.

VII.2 Relationship to the First Two Components of IMCI

The Multisectoral Platform for HH/C IMCI can make important contributions to the implementation of the first two components of IMCI, improving health worker skills and improving health systems:

- Efforts in literacy and basic education can increase the ability of community groups that are advising or managing health facilities to make meaningful contributions to the effective governance of these facilities;

- Efforts in literacy and basic education can make it easier for parents to understand the counseling given to them by IMCI-trained health workers, and to follow written instructions;

- Income-generating activities in the community can provide communities with more resources to pay for health services and to pay the salaries of health workers. This in turn can have a positive impact on the retention of health workers who are trained in IMCI. This is important given the expense involved in providing IMCI training;

- Income-generating activities in the community can make in easier for parents to purchase the full courses of treatment prescribed to them in health facilities for their sick children. They may make parents more likely to complete the course, and not save pills for future episodes of illness; and

- Improvements in the quantity and variety of food available can make it easier for parents of malnourished children to follow recommendations for feeding made by IMCI-trained health workers.

Many of these links between social and economic development activities and health-related behaviors will not happen unless program managers make specific efforts to promote those behaviors. While these social and economic development activities can be implemented even when the first two components of IMCI have not been implemented, their implementation makes it more likely that development activities will produce benefits in terms of child health and nutrition.

VII.3 The Role of NGOs in Implementing the Multisectoral Platform

The Multisectoral Platform expands the HH/C IMCI concept beyond health to include economic and social development activities that support the adoption of the key practices, and is similar in many respects to the concept of comprehensive primary health care advocated in the Alma Ata Declaration of 1978 (*92*). The Platform is viewed as indispensable by many PVOs and NGOs for one or more of these reasons:

- **Building The Confidence of Communities**: Many PVOs and NGOs have traditionally initiated their community-level activities by addressing problems to which the community assigns great importance. These initiatives might include providing access to potable water, increasing agricultural production, or incoming generating projects. Many times communities assign greater importance to these interventions than they do to health. Once the confidence of communities is earned through these initiatives, they can then turn their attention to health;

- **Effectiveness**: Other PVOs and NGOs have found that programs that attempt to implement health interventions in isolation have limited effectiveness. Sometimes communities are not responsive, as other more pressing needs have not been addressed;

- **Equity**: The introduction of user fees and other forms of cost recovery have brought issues of equity to the fore. IMCI as a strategy will have limited impact on morbidity and mortality if the most vulnerable groups, households and people are unable to benefit from programs or improved services due to their inability to pay for transport to health facilities, user fees, and health-related commodities such as mosquito nets, essential drugs, and food. This leads to the conclusion that interventions to improve equity are a crucial part of HH/C IMCI.

Ministries of Health generally have limited experience with this type of integrated approach to health and development. NGOs can help expand health services and promotive messages by advocating for participation by other Ministries/sectors in the promotion of health

messages. NGOs can disseminate examples of successful integration of health with social and economic development, and formulate guidelines for how to replicate this integration.

There is nothing inherently undesirable about programs focused exclusively on health. It is doubtful that the increases in child survival and control or eradication of diseases such as smallpox and onchocerciasis could have been achieved as quickly without a highly coordinated, centralized, and systematic endeavor. However, experience in the past 20 years in the NGO community and in the government health sector has begun to show that there are limits to such methods. In addition, there are serious concerns about the effects of these highly focused programs on the sustainability of a community's health actions, and on its long-term ability to take control of its own health. Another model exists, and NGOs have the opportunity to take the lead in more vigorously demonstrating its effectiveness.

VII.4 Debate About the Multisectoral Platform

While there are obvious benefits to communities when the Multisectoral Platform is put in place, a number of its shortcomings have been pointed out, including:

- This Platform may make the concept of HH/C IMCI so broad that it becomes difficult to explain to communities and partners what HH/C IMCI does and does not include, and difficult to develop and maintain a focus for field activities;
- Many feel that previous health initiatives that were broad or all-inclusive such as Comprehensive Primary Health Care, and Health For All by the Year 2000 had limited impact because they were so broad; and
- There are difficulties with scaling up due to the complexity of the program.

Table 11 summarizes and compares some of the arguments that have been advanced for narrower and broader approaches to HH/C IMCI.

Table 11 Arguments for a Narrower or Broader Approach to HH/C IMCI

	Argument for a more focused approach	Argument for broader approach
Analogy with past programs or policy initiatives	• More focused programs have been more successful: e.g. smallpox eradication. • The broader option is similar to comprehensive PHC and Health For All by Year 2000, both of which fell short of expectations.	• The greatest improvements in health have occurred when a broader social development agenda has been pursued: education, women's rights, income generation, etc.
Practicality, feasibility	• Just improving treatment of sick children in the community is complex enough: "We already have our hands full!"	• Communities are more responsive to broader programs that address their other priorities in addition to specific health interventions.
Selling the idea to countries and to organizations	• A narrower focus on improved treatment with specific tools and approaches is more attractive. • If the approach is too broad, people can't get a handle on what it is, they find it too vague. • Other initiatives/programs already address the broader issues.	• A broader approach is more attractive, and intersects with other interests of countries and donor organizations.

VIII. Linkages Between the HH/C IMCI Implementation Framework and Other Health Programs

VIII.1 Linkages With Other Health Programs

When IMCI was first introduced, it was anticipated that it could be a mechanism for countries to bring together various vertical programs addressing the health, nutrition and developmental problems of young children into one integrated program. While programs to control ARI and diarrhea in young children generally become fully integrated into national IMCI programs, other programs and initiatives continue to exist, and new programs and initiatives are being created outside of IMCI. These "other programs and initiatives" fall into two categories:

- **"Supra-IMCI"**: Programs and initiatives that are as comprehensive or more comprehensive than IMCI, by virtue of addressing the health needs of adults as well as children (reproductive health, maternal and child health), or by virtue of addressing or stressing a wider range of problems that affect children such as child labor, violence against children and mental development in early childhood. A prime example of the latter group is the Early Childhood Development (ECD) approach of UNICEF that is described in the 2001 UNICEF State of the World's Children Report (*93*). Many at UNICEF see the ECD approach as a broader framework for child health and well-being that includes IMCI as one of its several components.

- **"Infra-IMCI"**: Programs and initiatives that are less comprehensive than IMCI, focusing on just one or several of the many diseases or conditions targeted by IMCI. They usually aim to control the disease not only in children, but also in other groups such as adolescents, young adults or pregnant women. Although "less comprehensive" in terms of the health problems addressed, these programs may be comprehensive in terms of the wide range of sectors implicated, and the extensive effort invested in establishing partnerships across different government ministries and organizations. Examples include Roll Back Malaria (WHO), programs to address peri/neonatal health, nutrition programs that are either single intervention (breastfeeding, vitamin A, anemia) or comprehensive, immunization programs to eradicate single diseases (polio, measles) or strengthen routine immunization, and HIV/AIDS prevention and treatment programs.

Where linkages have been formed between these other programs and IMCI, the links have most often been with the first component of IMCI, improving the skills of health workers. The aim of these linkages has been to further refine the management of specific diseases, or to add the management of diseases not originally included in the IMCI clinical algorithms. Relatively little effort has been invested in linkages between HH/C IMCI and other programs. One reason for this has been uncertainty about what HH/C IMCI is. The HH/C Implementation Framework presented in this report can be a vehicle for forging links with other programs. Activities in these other programs can usually be placed within the three Elements in the framework, or in the Multisectoral Platform, as shown in Table 12. Doing this may demonstrate potential points of collaboration in implementation between programs with apparently different objectives.

VIII.2 An Example: Roll Back Malaria

The program for which linkages with IMCI have been pursued most systematically in the past few years is Roll Back Malaria (RBM) (*94, 95*). Roll Back Malaria is an initiative intended to halve the suffering caused by malaria by 2010. Several meetings have been held, most recently in Harare, Zimbabwe in November 2000, that have resulted in a framework for acceleration of the implementation of RBM and IMCI in the African Region. The six pillars of RBM are:

- Building and strengthening partnerships;
- Improving coverage of cost-effective technical interventions;
- Contributing to Health Sector Reform;
- Strengthening Health Information System and Research;
- Strengthening community participation; and
- Integration of malaria control activities into Primary Health Care.

This agenda is highly compatible with the three Components of IMCI, as well as with the Framework for HH/C IMCI presented in this report. Both have strong community components, and target the home as the locus for prevention and management of illness. In addition, RBM places emphasis on partnerships with private sector providers including drug sellers and shop owners as well as private firms. This corresponds well to the second Element of the HH/C IMCI Framework.

Table 12. Linkages Between the HH/C IMCI Implementation Framework and Other Health Initiatives

HH/C IMCI Framework	Roll-Back Malaria	Nutrition	Immunization	Peri/Neonatal	HIV/AIDS	Early Childhood Development (ECD)
Multi-sectoral Platform	• Collaboration with other sectors on • Production, packaging, sales, and distribution of drugs, nets, insecticides. • Limiting malaria transmission resulting from economic development (defo-restation, irrigation)	• Collaboration with other sectors working on agriculture production, food security, emergency feeding programs, income generation, etc.	• Support for vaccination by other government ministries and the private sector	• Collaboration with various services / programs aimed at women/families/ children to improve awareness of neonatal health	• Collaboration with other • Sectors on HIV/AIDS programs (including awareness, behavior change and care), education, agriculture, churches, MED, food security • NGOs/CBOs, self-help groups (youth/women); • Ministries of local government, labor, finance, information	• Development of comprehensive national ECD policies addressing the emotional, cognitive, social and physical development of the young child through inter-sectoral collaboration • Creation of a nationally defined and measured developmental check list
Element 1: Improving partnerships between health facilities (and services) and the communities they serve	• Collaboration between health services and communities on community-wide vector control • Community input into decision-making on malaria control	• Collaboration between health services and communities on growth promotion, nutritional rehabilitation, micronutrient delivery	• Communities work with health facilities and outreach teams to ensure all children and women of reproductive age are fully immunized	• Collaboration between health services and communities to improve neonatal care in the community and promote referral of ill newborns to health facilities	• Collaboration with clinics, hospitals and laboratories (if present) and outreach programs for awareness, HIV testing, referral, condom distribution, and surveillance • Community feedback into and co-management of HIV/AIDS programs	• Collaboration between health services, communities and parents on monitoring developmental milestones • Improved counseling and feedback by facility-based personnel on monitoring developmental milestones
Element 2: Increasing appropriate and accessible care and information from community-based providers	• Improved treatment of cases of malaria and promotion of malaria prevention by private providers, shopkeepers and traditional healers	• Improved nutritional counseling by private providers. • Growth monitoring and nutrition education by CHWs	• Promotion and support of immunization by CHWs, TBAs, and private providers	• Improved essential newborn care by birth attendants • Referral / treatment of sick newborns by CHWs and private providers	• Linkages with CHWs, TBAs, traditional healers, and private providers for awareness, referral for testing and treatment, home care counseling, condom distribution and reduction in risk from unsafe injections	• Improved early care and development by primary caregivers (e.g. mothers) through caregiver education/program given through CHWs and other community workers
Element 3: Integrated promotion of key family practices critical for child health and nutrition	• Improved home management of malaria. • Promotion of use of Insecticide Treated Materials integrated with other behavioral change activities	• Promotion of nutrition interventions and behaviors fully integrated with promotion of other key family practices	• Promotion of child and maternal vaccination integrated with promotion of other interventions/ services (e.g. vitamin A)	• Promotion of essential newborn care and appropriate care-seeking behavior integrated with promotion of other key family practices	• Promotion of condom use, STI referral, improved partner testing and commitment to monogamy; identification and support of HIV affected households /orphans • Reduction in transmission risk from injections, blood transfusion	• Promotion of emotional, cognitive, social and physical development of 0 to 5 year olds with focus on early stimulation and learning at home integrated with promotion of other key family practices

IX. Principles Underlying the HH/C IMCI Implementation Framework

IX.1 Overview of the Principles

Participants at the CORE Workshop "Reaching Communities for Child Health: Advancing PVO/NGO Technical Capacity and Leadership for Household and Community Integrated Management of Childhood Illness (HH/C IMCI)" held in Baltimore, Maryland, January 17-19, 2001 developed seven principles for implementation of HH/C IMCI after much discussion about what form implementation ideally should take (*1*):

1. HH/C IMCI can be implemented at national, district, and/or community levels, as appropriate.

A number of documents have been written suggesting that IMCI should first be introduced to policymakers at the national level, and incorporated into national health policy. While NGO representatives at the CORE workshop did not disagree with this, they also felt that it should not be a necessary condition for implementation of HH/C IMCI. In some countries where NGOs work, central governments are weak or non-existent. In other countries, waiting for adoption of IMCI at the central level would delay implementation of HH/C IMCI at the local level unnecessarily. While NGO representatives at the CORE workshop felt that HH/C IMCI has the most value when implemented at all three levels, it is valuable even when implemented at district and/or community levels only.

2. HH/C IMCI can be implemented by multiple actors or by a single organization.

Much emphasis has been placed on the importance of forming broad-based partnerships to implement HH/C IMCI. NGO representatives at the CORE workshop again felt that while this is the ideal situation, the implementation of HH/C IMCI should not necessarily be delayed by negotiations about these partnerships. While coalitions of organizations and groups, each with a specific role in implementation, may be most effective in implementing HH/C IMCI, any organization, given adequate human and financial resources, can make a difference.

3. HH/C IMCI recognizes the importance of curative and preventive interventions in the community for reducing child mortality and morbidity.

In the past some NGOs have invested their resources largely in the promotion of preventive interventions. At the same time, some groups have viewed IMCI (incorrectly) as primarily an approach for improving the management of sick children. The vision of HH/C IMCI is one which encourages all actors to make efforts to promote disease prevention, good nutrition, high-quality curative care and early childhood development. While implementation of HH/C IMCI may initially involve prevention only or curative care only, the eventual aim should be to promote an environment where children can grow with minimum risk to disease, recover rapidly from illness, thrive, grow, and develop to their full potential.

4. HH/C IMCI can be implemented with or without IMCI Components 1(Health Worker Skills) and 2 (Health System Supports).

All three IMCI components contribute to an effective life-saving strategy, and are synergistic. For example, improved quality of care will result from the implementation of the first two components of IMCI—improving health worker skills and improving health systems. Increased use of health services by the community resulting from implementation of HH/C IMCI, when combined with improved quality of care, will have a much greater impact on child health, nutrition and development than would either improved quality or increased usage alone. However, NGO representatives at the CORE workshop recognized that implementation of the first two components of IMCI is impossible in some settings, and will take many years to accomplish in other settings. Where necessary, HH/C IMCI can function independently and still make a major contribution to improved child health.

5. All three elements are requisite for HH/C IMCI

In establishing the three programmatic Elements as interlinked and requisite, NGOs at the CORE workshop set a higher standard for themselves—to assure that HH/C IMCI strives to connect both facility-based and community-based providers, and engage families for better health and nutrition through all major points of influence. All three programmatic Elements work synergistically to promote child health, nutrition and development in the community. If public facilities are non-existent within a reasonable distance from the community, and the area is not served by other health services such as mobile vaccination teams, there may be little alternative for immediate action on the first Element, except through advocacy for increased facilities and services.

6. Phased introduction of promotion of key family practices is acceptable.

Some of the most successful examples of program implementation presented at the CORE workshop were cases where programs had started with the promotion of one or two behaviors or interventions, and gradually added others over an extended period of time. Participants at the workshop thought that this was an approach to be emulated in many settings, especially where local capacity for implementation of complex interventions is limited. A communication and behavioral change strategy needs to be constructed in a time and sequence that builds upon progress made and confidence gained at the individual, household and community levels.

7. Phasing of introduction of the three elements is acceptable.

Prioritization for implementation of elements should be done based on assets and needs analysis at district and community levels.

IX.2 An Example of the Principles in Action: Community-based IMCI in Nepal

An example was presented at the CORE workshop by Penny Dawson of JSI/Nepal on how a project in Nepal that originally focused only on community management of pneumonia has expanded over time to include management of the wider range of diseases covered in IMCI training, and to serve a far larger target population (*96*). This project exemplifies the seven principles of HH/C IMCI implementation presented in the preceding section. It is noteworthy that the project started by dealing exclusively with case management of childhood pneumonia (*97, 98*), and only expanded to address the full range of conditions targeted by IMCI several years later.

In 1993, it was calculated that overall only about 15 percent of expected pneumonia cases were being brought by caretakers to the government health facilities for assessment and care. In 1993 the MOH, USAID, JSI, UNICEF, and WHO formed a working group to develop an approach that would bring much needed pneumonia diagnosis and treatment closer to children. The primary strategy was to extend pneumonia case detection beyond the fixed facilities through Community Health Workers (CHWs). The CHWs were trained to follow the WHO guidelines for standard case management at the community level. Cases of severe pneumonia or very severe disease were referred to the nearest health facility with a trained worker.

Since it was not clear whether or not these CHWs would be able to successfully conduct diagnosis and treatment, it was decided to initiate two different intervention models: a treatment model in which pneumonia was diagnosed and treated by the CHW, and a referral model in which the CHW diagnosed and referred all cases of pneumonia, severe pneumonia, or very severe disease, to the nearest trained health worker. Antibiotics were provided free of cost at both the community and health facility levels. An external assessment was conducted in 1997. For all cases of ARI assessed, the classification was correct in 81 percent of cases, and total case management was correct in 80 percent. In addition, community-based treatment doubled the percentage of expected pneumonia cases that were identified and appropriately treated. Cautious expansion of the "treatment" model was recommended.

In 1998/99, five more districts were added in collaboration with four international NGOs working in Nepal (ADRA, CARE, PLAN, and Save the Children/US) to maximize monitoring and support of the Community Health Workers. At the same time, diarrhea, nutrition/vitamin A, and immunization were included in the training package. The program was renamed the Community-Based ARI/CDD (CBAC) Program. From July 1999, the experience of these previous programs was combined with the Integrated Management of Childhood Illness (IMCI) initiative under the name Community-Based IMCI (CB-IMCI).

The original 11-day IMCI training course for Health Workers at Health Post and Sub-Health Post levels has been revised into a nine plus two-day training course. The two additional days cover program management training, which was lacking in the original IMCI approach. To date, through all the Community-Based Child Health Programs, a total of 1,367 health facility staff and 8,646 Community Health Workers, including 7,491 FCHVs, have been trained in the standard case management of pneumonia. Over 125,000 village mothers have been oriented by their FCHVs to the signs of pneumonia, appropriate home care, and when and where to seek help. By July 1999, the percentage of expected pneumonia cases receiving treatment in the initial program districts had reached 50 percent, with over half of the cases treated by the FCHVs. This

nearly three-fold increase in children reached, combined with information on the quality of case management, strongly suggests that this program is having a substantial impact on child mortality in Nepal.

This example demonstrates the following principles:

1. HH/C IMCI can be implemented at national, district, and/or community levels, as appropriate: The project started at the community level and expanded to the district and national levels over time, instead of starting at the national level.
2. HH/C IMCI can be implemented by multiple actors or by a single organization: The program started with a limited set of actors and gradually expanded to develop a broader network of partnerships with PVOs, NGOs and community-based organizations over time.
3. HH/C IMCI recognizes the importance of curative and preventive interventions in the community for reducing child mortality and morbidity. The initial focus was on curative care of pneumonia, but additional curative and preventive interventions continue to be added.
4. HH/C IMCI can be implemented with or without IMCI Components 1 (Health Worker Skills) and 2 (Health System Supports). Implementation started long before IMCI was introduced to Nepal with community-based initiatives. Eventual implementation of the first two components of IMCI will help reduce mortality further.
5. All three Elements are requisite for HH/C IMCI (except Element 1 if health facilities and services do not exist). The program started with Element 2, curative care by community-based health workers, but is expanding over time to include the other two Elements.
6. Phased introduction of promotion of key family practices is acceptable. Promotion of additional practices is being added gradually to the program.
7. Phasing of introduction of the three Elements is acceptable. Phasing has been a key feature of the program.

X. Community Mobilization in HH/C IMCI

X.1 Introduction

A process of community mobilization within each community is critical for a successful HH/C IMCI program (*84, 99*). Community mobilization for health is defined as action stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to solve health problems. Community mobilization is not a campaign or a series of campaigns at the community level. Rather, it is a continuous and cumulative process of communication, education, and organization that helps produce a growing autonomy within a defined community by building leadership and implementation capacity. Community mobilization is based on a high level of community participation and encompasses a wide range of community level activities that address a community's health needs. While this report does not directly address strategies for community mobilization, processes for community mobilization and participation are critical to the impact and sustainability of HH/C IMCI efforts (*84, 99*).

Many community development providers believe that the highest level of community participation is defined by maximum community leadership in the process of identifying, planning, organizing, and mobilizing resources for community-level health activities, and that this level of community participation results in the greatest health impact and sustainability in the long-term. Participatory processes such as PRA and PLA, advocated by some governments such as Uganda as a key part of their HH/C IMCI strategy (*100*), may embody the maximum community participation. This is especially true if the non-health project activities determined by the community to be critical to their health outcome are derived from a participatory community planning process. It also implies that health-related organizational structures, resource allocation processes, and collaboration with other stakeholders needs to be tightly coordinated in order to respond to community needs outside of the MOH's mandate.

NGOs have promoted community involvement in collecting, interpreting and using health information in several ways:

- Use of participatory approaches such as Participatory Learning and Action (PLA) to examine the health priorities and needs of different groups of people in the community, often during the development of a health program or intervention (*84, 99, 100*);
- Community-based monitoring systems where community members collect information on variables such as births, deaths, illness episodes, heights and weights of children, immunization rates and sales of mosquito nets;
- Verbal autopsy methods that allow for community involvement in investigating and defining causes of death in young children (*101, 102*); and
- Positive Deviance methods that identify parents or families that have been successful in maintaining the health and nutrition of their children even in the face of difficult economic and environmental conditions (*86*).

Information collected can be used by community members to plan and evaluate health promotion activities they themselves conduct, and can also be fed into health information systems based in Ministry of Health facilities.

The scope for community involvement and the degree to which communities can take a leading role in planning and carrying out activities varies according to the Element in the Framework. Table 13 provides examples of commonly used community-level activities that are appropriate to each of the programmatic Elements in the HH/C IMCI Implementation Framework. Levels of community participation can vary within any of the three programmatic Elements, as well as within each specific community-level activity. A "ladder" of community participation is often used to show the different degrees of community and professional health worker participation according to criteria of leadership, community organization, and resource mobilization. One moves up the "ladder" toward increasing community participation and decreasing health worker participation. This maximum level of community participation is often associated with "community empowerment" approaches (*103*).

Table 13. Relationship Between the HH/C IMCI Implementation Framework and Community Level Activities

	Examples of Commonly Used Community-Level Activities
ELEMENT ONE Improving partnerships between health facilities or services and the communities they serve	• Health Days • Outreach Services • Community Health Management Committee/Board Formation and Training • Community Health Volunteer Training in Referral • Community-Defined Quality
ELEMENT TWO Increasing appropriate, accessible care and information from community-based providers	• Community Health Volunteer Formation and Training in Case Management • Training/Involvement of Traditional Healers and Other Private Providers • Drug Revolving Funds • Village Health Committee Formation and Training • Community Health Management Committee Formation and Training • Interactive Theatre • Community Based Alarm and Transport Systems
ELEMENT THREE *Integrated* promotion of key family practices critical for child health and nutrition	• Community Health Volunteer Formation and Training in Promotion, Prevention, and some Treatment • Community-Based Organizations Formation, Engagement and Training • NGO Capacity Building to Deliver Preventive and Promotive Services • Peer Support Group (i.e. Mothers Clubs) Formation and Training • Appreciative Inquiry Planning Processes • Positive Deviance Inquiry • Training Community Health Volunteers in Growth Promotion • Village Health Committee Formation and Training
MULTI-SECTORAL PLATFORM	• Community Insurance Schemes • Savings and Loan Programs (Credit Revolving Funds) • Water and Sanitation Programs • Literacy with Health Education • Child to Child Programs/Educational Support • Transformational Leadership Training • Community Resource Persons and Community-Based Organizations Formation, Engagement and Training • Positive Deviance Inquiry
EXAMPLES OF ACTIVITIES RELEVANT TO ENTIRE FRAMEWORK	• Participatory Learning and Action/Participatory Rapid Appraisal • Training and Capacity Building of Community Resource Persons/Community Health Volunteers • Community Development Approaches • Formation of Networks and Associations of Community Health Volunteers • Community Epidemiology (community collection of data, followed by regular analysis and decision-making in meetings) • Gender Relations Analysis • Theatre and Media (radio, posters, print materials)

Several factors play an important role in the determination of the balance of community and MOH or NGO participation. Examples of factors that might influence the project design in favor of professional health worker leadership include time-sensitive performance targets for a project, a facility, or an individual; political events; cultural acceptance of behavioral norms not conducive to good health; and public health emergencies (such as epidemics). An HH/C IMCI approach seeks to balance, blend, and complement scientific and technological know-how with local knowledge and expertise. In general, these factors will vary by HH/C IMCI programmatic Element. Table 14 demonstrates how factors will influence the initiative to identify, prioritize, and design a response to a health need.

Table 14. Blending Community Participation with Needs of MOHs and NGOs

	Interaction between MOHs, NGOs and communities
ELEMENT ONE Improving partnerships between health facilities or services and the communities they serve	The MOH or NGO may feel compelled to lead the process in order to meet quality targets established for the facility or project. However, there is much scope for communities to participate in advisory or management boards for health facilities.
ELEMENT TWO Increasing appropriate, accessible care and information from community-based providers	The MOH or NGO may feel compelled to determine the need for community-based treatment services based on epidemiological information in the target area. However, the design of services will require participation by community actors (for example, to form drug revolving funds managed by village committees).
ELEMENT THREE *Integrated* promotion of key family practices critical for child health and nutrition	The MOH or NGO may define the need and priority for behavioral change based on survey information. Or the community may identify the need for better health behaviors due to previous exposure to IEC campaigns or visits to other communities. In either case, behavior change communication strategies need to be guided by the community and its knowledge, practices, and local beliefs to be effective.
MULTI-SECTORAL PLATFORM	The MOH or NGO may act as a facilitator to guide a community-led planning process that results in activities that the community prioritizes as critical to their own health needs, thereby securing their participation and contribution of resources. Community priorities may differ greatly from those of the MOH or NGO.

Table 15 describes key steps in the identification, planning, execution, use, and evaluation of any community-level activity. The process of identifying the key action agent for each step of a community-level activity can be a useful exercise to build upon the strengths of the community, the professional health worker, and the PVO or NGO. It can assure appropriate participation by each actor while acknowledging these other factors. By involving the community to some degree in each of the steps, a community's contribution and support of community-level activities can be maximized leading to the success of the activity.

Table 15. Defining Participation in Different Phases of Critical Community-Level Activities

WHO?	STEPS IN ANY COMMUNITY-LEVEL ACTIVITY						
WHO Leads? Consults? Facilitates? Participates?	Identifying and prioritizing need	Designing a response to a prioritized need	Organizing the delivery of services	Delivering the services or activity	Consuming the services or participating in the activity	Analyzing (monitoring and evaluating) the results of the activity	Re-prioritizing and responding to a need
Community							
Professional Health Worker (MOH)							
PVO or NGO Health Worker							

X.2 Participatory District and Community Assessment and Planning

A successful HH/C IMCI program is one that carefully but creatively responds to a specific community or district context, building upon community strengths and MOH assets. It requires the crafting of resiliency and adaptability into overall design as well as maximizing the participation of all stakeholders where possible. HH/C IMCI is not one community-level activity but a series of iterative community-level activities planned, acted upon, analyzed, and then planned again to improve child health and nutrition. A district-level participatory planning and assessment process is critical to a successful HH/C IMCI program. Guidelines that NGOs have used in child survival projects which can guide district planning processes include:

- The HH/C IMCI initiative has to occur within a context of general district strategic planning for health.
- HH/C IMCI is not new or separated, but builds on existing community and district structures and activities.

- Active partnership with district health authorities and other health players (international and local NGOs, municipalities, large-scale employers, literacy groups, micro-credit groups, development groups, teachers, and communities) is essential from the beginning.
- The HH/C IMCI initiative needs to establish or reinforce a process for selecting, implementing, and sustaining child health activities that will be ongoing and include community input.
- The essence of HH/C IMCI needs to be the communities' participation in and ownership of activities for their own health promotion (*104*).

The planning process is critical to:

- Decide whether to implement HH/C IMCI or not;
- Build support and community assessment capability at the district and sub-district levels;
- Decide which activities from each Element are critical to improve child health and nutrition; and
- Develop an implementation plan including a monitoring and evaluation strategy (*105*).

XI. Leadership and Advocacy for HH/C IMCI: The role of NGOs

XI.1 Advocacy and Leadership to Promote Community Approaches to Child Health, Nutrition and Development

Communities cannot provide all of the resources needed to implement the health and nutrition interventions that they require. Advocacy is needed to mobilize resources from other levels (national, international) and from the private sector. Many governments and health organizations have yet to make a real commitment to the IMCI approach. U.S.-based NGOs (PVOs) have tremendous experience with advocacy at the national and international levels, as well as with fund-raising from private donors within the United States. A recent example is the success of NGOs working on the control of eye diseases and the prevention of blindness to make elimination of diseases such as trachoma and onchocerciasis a global priority. More work needs to be done to adapt the lessons learned from advocacy and fund-raising in the United States for various partner organizations working on child health in other countries.

In addition to advocacy, leadership is needed at the district and national levels to harmonize approaches and methods for improving child health and nutrition and promote policies necessary for the implementation of IMCI. NGOs have participated in national IMCI committees, and have been instrumental in promoting the adoption of IMCI as an official policy of Ministries of Health. Many NGOs have also begun to help establish and participate in district IMCI task forces or steering committees. The ability of NGOs to use their own health and development programs as examples of the feasibility and effectiveness of integrated approaches to child health and nutrition is a key to the effectiveness of their leadership.

NGOs have had many years of success with child health and nutrition programs implemented at the community and district levels. A key challenge now before NGOs is to scale up these programs to the state and national levels so that morbidity and mortality can be substantially reduced. Scaling up inevitably involves forming partnerships with a variety of organizations, including various government ministries, community groups, and the private sector.

XI.2 Role of NGOs in Leadership and Advocacy

The key role played by PVOs/NGOs in health delivery and community mobilization has been well documented. PVOs/NGOs are increasingly becoming key partners with governments and collaborating with international agencies at global, national, regional and district levels to positively impact on health systems, particularly under decentralization. The CORE NGOs alone work collaboratively in more than 140 countries in primary health care and multi-sectoral development programs. CORE has illustrated the considerable success and ripple effect that can be achieved when PVOs/NGOs come together under one umbrella to promote common goals and agendas. The NGO community shares institutional commitments to social justice, equal access to health care facilities, and sustainable development, all of which are key components to the underlying philosophy of IMCI. NGOs have developed substantial expertise in the following areas, which can contribute to HH/C IMCI:

- Service delivery, training and technical assistance to at-risk populations at the peripheries;
- Sustainable long-term presence in country with skills in community organization, mobilization, and behavior change communication;
- Strategies to increase partnerships with and facilitate linkages between the MOH and local community organizations;
- Formation, training, support, and development of associations or networks of community health workers, mothers groups and other community groups;
- Collaborative planning methodologies to support district health and local government offices to work with multiple stakeholders to scale up community-based activities;
- Integrated work in health, education, micro-enterprise and democracy promotion; and
- Ability to attract diverse private, bilateral, and international resources to improve community health.

Through their work based in communities, with districts, and in national forums, NGOs have a strategic niche to fill in promoting HH/C IMCI. NGOs have a strategic niche for expanding community access to IMCI through:

- *Directly Reaching the Child*. NGO health programs have developed community based health information systems to better target families and children in need, and to mobilize communities to take action against their key health problems. Field projects which impact children include school health programs, child survival programs that may include direct health care provision, and integrated development programs that improve the environment for the child.

- *Working with Caregivers, Households and Families*. NGOs work with families in the context of community health education, literacy classes, micro-enterprise and environmental sanitation. These programs help reduce social barriers to health care and disease.

- *Creating an Enabling Community Environment.* NGOs work with community leaders and groups to positively reinforce or change community norms to better support health behaviors. Work in this area includes creation of linkages between the community and the health delivery system; strengthening community groups to manage health facilities and programs; strengthening of community-based providers to support or provide quality health information and services; and development of creative solutions for cost recovery to increase sustainability of the programs.

- *Strengthening Health Facilities*. NGOs link communities with health facilities to support them and increase recognition of the health facilities as an important community resource. Activities include outreach and mobile clinic programs, training health workers to better provide key health services and counseling identified by the community, and implementation of health facility assessments complemented by on-the-job training and support to strengthen key skills.

- *Expanding Service through District Level Collaboration and Capacity Building*. NGOs partner with district health authorities and other local NGOs to build their capacity and to reach communities more efficiently. Participatory planning techniques, joint monitoring

and assessments, action research, and inter-sectoral coordination are among the elements already in place through NGO support.

Given the experience of NGOs in initiating and supporting community-based development in general, they have a highly significant role to play in all areas of IMCI. In addition to Community IMCI, NGOs may also have key competencies relevant to facility-based IMCI (IMCI Components #1 and #2) which may include the following:

- Planning an IMCI strategy with the health facility staff.
- Planning and conducting health facility assessments with MOH and other partners for quality assurance.
- Training health facility staff, especially auxiliary staff, in IMCI.
- Supporting health systems development including facility organization and management, and referral systems and transportation services linked to community groups.
- Developing and conducting a monitoring and evaluation strategy with health facility and District Health Office staff, using existing tools.

XI.3 Role of the CORE Group in HH/C IMCI

The CORE Group has been active in helping to conceptualize and implement activities in IMCI Component 3, Improving Household and Community Practices (HH/C IMCI). At the global level, CORE has been a member of an Inter-Agency Working Group (IAWG) on Community-IMCI along with UNICEF, WHO, PAHO, USAID, the World Bank and others. This group has helped to define general policy guidance for Community IMCI and to facilitate its development and early implementation. This group has helped formulate a list of 16 Key Family Practices for promotion, and recommended principles for Community-IMCI implementation, along with other tools.

At the regional level, CORE has worked in partnership with PAHO to field test tools and to help define appropriate communication and behavioral change strategies. PAHO estimates that at least 200,000 Community Health Workers are active in the Americas but that in the majority of countries, they are inadequately linked to health services. PAHO is in the process of revising a Community Health Worker Training Course and a “Talking with Mothers Module” based on field tests with MOHs, PVOs, and NGOs.

At the national level, CORE members and other PVOs/NGOs have become active members of HH/C IMCI inter-agency taskforces. NGOs help bring their child survival experience at the district and community level to the policy table. In some countries, NGOs have worked with the MOH to adapt the IMCI algorithm used for facilities to the level of community health workers. In other countries, NGOs have helped identify best tools and practices that can be used at the country level.

At the district and community levels, CORE members have become engaged in district-level planning activities to orient their Ministry of Health colleagues to HH/C IMCI and to collaborate with them and other counterparts to more effectively reach and engage communities in child health promotion, service delivery, and preventive medicine programs. Given the newness of the third component of IMCI (HH/C IMCI), many challenges remain for its effective implementation. The most important challenge is to find opportunities and linkages with other

partners to take known and tried approaches more rapidly to scale so that children's health, nutrition, development and well being improve. Other challenges are:

- To replicate the collaboration, sharing, and leadership demonstrated by the CORE Group at the US level, to national levels in other countries;
- To promote greater MOH/NGO collaboration so that the voices of the NGOs can help set appropriate policies that will promote sustainable community solutions to maximize child health; and
- To better document success stories and lessons learned so they are not forgotten and repeated, but are used and adapted to become even more effective.

XII. Tools and Manuals on IMCI

XII.1 Internet Resources on Child Health and IMCI

Websites on child health in developing countries

The following websites offer general information on child health in developing countries:

Website	Organization
http://www.usaid.gov/pop_health/cs/index.html	USAID, General information on child survival
http://www.usaid.gov/hum_response/pvc/child.html	USAID, Bureau of Private Voluntary Cooperation (BHR/PVC)
http://www.coregroup.org	CORE Group
http://www.childsurvival.com	Child Survival Technical Support Project (ORC Macro)
http://www.basics.org	The BASICS II Project
http://www.whoafr.org/home/healthtopics.html	WHO/AFRO in Harare, Zimbabwe, General information on health topics
http://www.who.int/chd/	World Health Organization, Division of Child Health and Development (WHO/CHD)
http://www.paho.org/	Pan American Health Organization
http://www.unicef.org/gmc/	UNICEF, Home page for Global Movement for Children
http://www.unicef.org/programme/health/aprogs.htm	UNICEF, Home page for child health programs
http://www.international-health.org/ARCH/index.html	Boston University, The ARCH Project: Applied Research on Child Health
http://www.childhealthresearch.org/	Child Health Research Project
http://ih.jhsph.edu/chr/fhacs/fhacs.htm	Johns Hopkins University Family Health and Child Survival project
http://www.icddrb.org/	Center for Health and Population, Bangladesh

Websites on IMCI

The following websites offer information specifically on IMCI in developing countries:

Website	Organization
http://www.coregroup.org/working_groups/childhood.cfm	CORE Working Group on IMCI
http://www.coregroup.org/resources/meetings /imci_jan_01/IMCI_workshop.html	Presentations from CORE Workshop on HH/C IMCI, Jan 2001
http://www.who.int/chd/publications/imci/index.htm	WHO/CHD, Publications on IMCI
http://www.childsurvival.com/kpc2000/kpc2000.cfm	ORC/Macro CSTS Project, KPC 2000 household survey
http://www.unicef.org/programme/health/child /imci_tools.htm	UNICEF, Programming and Advocacy Tools for implementing IMCI

XII.2 Tools and Manuals on IMCI in General or the First Two Components of IMCI

For facility-based IMCI, the major tools are the treatment algorithms in various forms: wall chart, booklets etc, and the courses are the case management courses that teach providers how to use the algorithms. These are the most familiar tools and courses, and in some ways are prototypical of the IMCI approach. For the household and community component of IMCI, tools and courses can be developed for three different groups of providers: facility-based health care providers, non facility-based providers, and community organizations.

Integrated Management of Childhood Illness (IMCI) Information Kit
WHO Department of Child and Adolescent Health and Development (CAH) &
Health Systems and Community Health (CHS). 1999.

Purpose

This information kit provides a general introduction to the Global IMCI Strategy. It is useful for orienting an organization as to the overall rationale, global status, and scope of IMCI and its component interventions. It may also be especially appropriate for senior managers, or other non-child health staff, or for a NGO just becoming involved in IMCI.

Contents

This kit consists of twelve (12) information sheets, covering topics such as:

- Management of Childhood Illness in developing countries: Rationale for an integrated strategy;
- Integrated Management of Childhood Illness: Global Status of Implementation;
- Planning National Implementation of IMCI;
- Adaptation of the IMCI Technical Guidelines and Training Materials;
- IMCI Training course for first-level health workers: Linking Integrated Care and Prevention;
- Follow-up after Training: Reinforcing the IMCI Skills of First-Level Health Workers;
- The Role of IMCI in Improving Family and Community Practices to Support Child Health and Development;
- Update on Development Projects to Support IMCI;
- IMCI Research Priorities: Investigating Methods to Prevent and Manage Childhood Illness;
- Introducing IMCI into Pre-Service Training for Health Professionals;
- IMCI Indicators, Monitoring, and Evaluation;
- IMCI and Health Sector Reform;
- Building Partnerships for Child Health.

Ordering Information

WHO Department of Child and Adolescent Health and Development (CAH)
Health Systems and Community Health (CHS)
1211 Geneva 27, Switzerland
Document no.: WHO/CHS/CAH/98.1 A-M Rev.1 1999
Telephone: 41-22-791-2632 Fax: 41-22-791-4853
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Internet:- www.who.int/chd/publications/imci/index.html

Integrated Management of Childhood Illness: A WHO/UNICEF Initiative
Bulletin of the World Health Organization, Supplement No 1 to Volume 75, 1997

Purpose

This special supplement to the Bulletin of the WHO is the definitive set of journal articles describing the technical basis for the IMCI case management guidelines (facility-based), and reporting on the development and field-testing of the IMCI training course for first-level health workers.

Contents

There are twelve (12) articles in all. Results are based on studies in The Gambia, Tanzania, Uganda, Ethiopia, Kenya, and Bangladesh. The first article provides an overview of the technical basis for IMCI, i.e. experience with the diarrheal disease (DD) and acute respiratory illness (ARI) control programs of the past decade. Included in this first article are tables and figures showing:

- Changes in the draft, pretest, field-test and final versions of the facility IMCI algorithm;
- "Wall-charts" consisting of:
    - The classification tables for IMCI, based on four main symptoms (cough, diarrhea, fever, ear problem), and nutritional status;
    - Instructions to mothers on giving oral drugs at home;
    - Instructions for treating diarrhea and dehydration;
    - Feeding recommendations for children by age group, and for a child with persistent diarrhea;
    - Counseling the mother about feeding problems.

Topics of other articles include:

- Efficacy evaluations of the IMCI algorithm in various epidemiological settings;
- Field-testing of the IMCI Training Course, in terms of health worker performance;
- Sensitivity testing of the referral component of the algorithm;
- Assessments of potential indicators of anemia and protein-energy malnutrition.

The concluding article on the IMCI guidelines draws together the results of field studies on their effectiveness, and identifies key issues that need to be addressed. It also describes the process for adapting the guidelines to specific country situations, presenting the broader IMCI strategy.

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Rapid Assessment and an Integrated Checklist for Supervision
Youssef Tawfik, the BASICS II Project, Arlington, Virginia

Purpose

These tools are designed to assist primary health care supervisors in conducting effective supervisory visits. The Rapid Assessment Tool focuses only on measuring health workers' skills in child survival services, whereas the Integrated Checklist covers all aspects of primary health care services.

Contents

BASICS developed and tested both tools in Niger in partnership with the Quality Assurance Project. These two worked together to help the Ministry of Health improve the quality of primary health care services, especially child survival. The Rapid Assessment Tool was particularly effective in structuring child survival supervision and generating needed data to monitor progress in health workers' skills. The Integrated Checklist is comprehensive, and therefore, may require further adaptation.

The joint project realized that supervision is essential to supporting health workers and maintaining their level of knowledge and skills. Yet, effective supervision can only be conducted with the help of structured supervisory tools. When the Rapid Assessment Tool was used to measure the impact of health workers' training, it succeeded in detecting progress in the ability of health workers to counsel mothers about the sickness of their children and to minimize missed opportunities. Supervision, when effective, is essential for maintaining health workers' skills. Supervisory tools are necessary to structure the supervisory visit and to generate data needed to monitor projects. In designing a supervisory tool, it can be difficult to balance simplicity with comprehensiveness.

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XII.3 Tools and Manuals on HH/C IMCI

Improving Family and Community Practices: A Component of the IMCI Strategy
World Health Organization and UNICEF. 1998. WHO/CAH/98.2

Purpose

This general document represents WHO and UNICEF's consensus on the scope of Community IMCI. It is intended primarily to summarize their views on twelve (12) Key Family Practices necessary for improved child survival, growth and development, and to suggest activities to improve family and community practices in these regards.

Contents

This document reviews the three components of the Global IMCI Strategy, summarizing priority problems affecting child survival, and explains and lists the Key Family Practices. It includes a useful table on "How to Build and Strengthen Community Resources to Promote Improved Nutrition." This table lists, for each Key Family Practice, a sample community resource, and activities in three different settings:

- Where the resource exists and is effective;
- Where the resource exists but needs strengthening;
- Where no resource exists but a need has been identified.

The document also includes a table of "Tasks in Planning and Implementing Activities to Improve Family and Community Practices."

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E-mail: cah@who.int
Internet: http://whqlibdoc.who.int/hq/1998/WHO_CAH_98.2.pdf

An Inventory of Tools to Support Household and Community Based Programming for Child Survival, Growth and Development

Purpose

This is a far more comprehensive inventory than what is found in this report on tools, manuals, materials and documents for the implementation of programs to promote child health, nutrition and development. A feature of the inventory is the inclusion of websites from which materials can be downloaded.

Contents

The inventory is divided into six sections:

- Training tools for lay and community health workers;
- Integrated communication and implementation strategy development;
- Information, education, communication materials;
- Working with the community;
- Monitoring and evaluation tools;
- Workshops, reports on national, local and community based programs;

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Download from: http://www.unicef.org/programme/health/child/imci_tools.htm

Or write to:

Programme Division, Health Section (T-24A)
UNICEF
3 United National Plaza
New York, NY 10017
Fax: 212-8246460/6462

Guide to Assessment Process for Planning Household/Community IMCI (Draft)
Inter-Agency Working Group (IAWG) Sub-Group for HH/C IMCI. 2000.

Purpose

This tool has been developed to assist "groups at the national and district levels with a participatory assessment and analysis process that feeds into the overall planning cycle for the implementation of community/household IMCI (C/HH IMCI). It aims to complement the introductory, planning, and monitoring and evaluation phases that are also necessary for implementation of C/HH IMCI. It assumes that the introductory phase has been completed, and the decision made at the national level to undertake its implementation. It also assumes that a national-level IMCI implementation committee or some comparably committed group already exists."

The framework for this tool is based on principles essential for all *sustainable* community-based primary health interventions, such as: community participation and ownership of activities; a context of district strategic health planning; building on existing community and district structures and activities; and early and active partnership with district health authorities and all other health players (NGOs, municipalities, large-scale employers, development groups, etc.).

Contents

Using secondary data and direct interviews, this tool covers four cycles of situational assessment and review. Each progressive cycle covers the issues in greater depth, and is carried out increasingly closer to the community: 1) National- and 2) District level Considerations for Planning C/HH IMCI; 3) In-Depth Assessment at District and Community Level for Planning; and 4) Developing an Implementation Plan at the District and Community Level. While the process may logically start at the national level and work downward, it may also be possible to initiate C/HH IMCI activities at the district level if there are difficulties with implementing IMCI at the national level. These key behaviors guide both the process and the outline of expected C/HH IMCI interventions represented in the tool.

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Participatory Community Planning for Child Health: Implementation Guidelines. Bhattacharya, Karabi and John Murray. 1999. BASICS II Project, Arlington, Virginia.

Purpose

This tool is intended to help "health staff and communities to jointly identify and prioritize health problems and to develop plans to solve them." It uses "information collected on maternal and child health behaviors and is designed for district and sub-district program and health staff." The method described has four main objectives:

- Develop a community health action plan with full participation and consensus of communities, via immediate use and analysis of collected information.
- Develop above plan based on a limited number (16) of primary health care behaviors documented to improve maternal and child health.
- Collect key indicators for monitoring and evaluating community and household activities, using an integrated household survey.
- Build capacity of local staff and communities to develop and evaluate community programs.

The document uses a flexible time plan that can be implemented in 8–10 days, and has been field-tested in various forms in Zambia, Ethiopia, Morocco, Guinea (Conakry) and Brazil. It is designed to help *begin* a process of change in the way health planning is done at the local level.

Contents

These implementation guidelines include a description of the overall design, and the four (4) phases of the process, that are: 1) Building Partnerships, 2) Selecting the Emphasis Behaviors, 3) Exploring Reasons for the Behaviors, and 4) Developing the Action Plan.

Included are suggestions for training, assessment forms with each section, a household survey instrument, figures demonstrating use of a grid to select households and a sample action plan, a random number table, an indicator summary sheet with examples filled in, and example matrix ranking and decision value tables.

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Health Education in Primary Health Care Projects: A Critical Review of Various Approaches Valerie Stetson and Robb Davis. 1999. CORE Group

Purpose

The purpose of this paper is "to offer NGOs (non-governmental organizations), especially US-based PVOs, and other interested organizations a comparative review of health education approaches and research and data collection methodologies associated with them."

Contents

The paper explicitly highlights differences and similarities in the theoretical base, worldview (assumptions about education "teacher and learner"), and problem analysis of different health education approaches. It includes also a description of the resources required, research/data collection methods, and critiques of each approach.

The review includes a series of case studies to provide readers examples of how the approaches have been applied in the field. It also includes a set of questions to assist NGO headquarters and field staff to critically analyze choices about the particular health education approach best suited to their situation, and to more deliberately choose an approach that is congruent with their organizations goals and values. Health education approaches are divided into three categories:

- Conventional Health Education
- Health Communication
    - Social Marketing
    - Behavior Change Communication
- Empowerment Health Education
    - Popular Education
    - Community "Organization"

Ordering Information

CORE Group
Download from: http://www.coregroup.org/publications_files.cfm

Community-Based Primary Health Care Implementation Guide: A Practical Guide for the Organization of Community Health Activities

Purpose

This implementation guide was developed from the experiences of the Catholic Relief Services health staff working in Battambang Province, Cambodia. The CRS Community-Based Primary Health Care Project began in mid-1994 and evolved out of an earlier program that provided technical and material support to district hospitals and commune health centers in two rural districts.

Contents

The guide contains twelve chapters:

- Definitions (What is Primary Health Care?)
- Preparing to Start
- Program Development Process
- Site Entry and Finding People to Work with You
- Other Village Health Workers
- Learning about the Community
- Solving Health Problems with the Community
- Information, Education and Communication for Health Behavior Change
- Village Health Projects
- Health Center and Community Co-Management Co-Financing Committees
- Monitoring and Evaluation
- Community Health Self-Management and Sustainability.

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Catholic Relief Services
209 West Fayette St.
Baltimore, MD 21201
Tel: (410) 625-2220
Fax: (410) 234-3189
www.catholicrelief.org

Training Materials for Community Health Workers on Diagnosis and Treatment of Sick Children outside of Health Facilities

Both CARE in Siaya, Kenya and JSI in Nepal have pioneered approaches to training community health workers and other volunteers on the diagnosis and treatment of sick children outside of health facilities. Materials available include training materials and algorithms for assessment of sick children.

Materials for the JSI/Nepal project can be ordered from:

Penny Dawson
Team Leader, JSI/Nepal
PO Box 1600
Kathmandu, Nepal
Tel: 977-1-524313
Fax: 977-1-535104
E-mail: penny@jsi.wlink.com.np

Materials for the CARE/Siaya project can be ordered from:

David Newberry
c/o CARE
151 Ellis St NE
Atlanta, GA 30303
Tel: (404) 681-2552 (main number)
Fax: (404) 589-2624

Rapid, Sustained Childhood Malnutrition Alleviation through a Positive-Deviance Approach in Rural Vietnam: Preliminary Findings. In HEARTH Nutrition Model: I. Applications in Haiti, Vietnam, and Bangladesh. Ed. Wollinka, O., Erin Keeley, Barton R. Burkhalter, and Naheed Bashir.

Purpose

This report summarizes Save the Children's early experience with community health volunteers (CHVs) in its Poverty Alleviation and Nutrition Program (PANP) in Vietnam. This program used a positive-deviance approach to enable families to improve and sustain their children's nutritional status after rehabilitation. Positive-deviance is well suited to communities where a problem is common, recognized, important and remediable through behavior modeled within community norms. The process galvanizes households at risk in poor communities to quickly identify and adopt affordable, lasting solutions to vexing problems from their own impoverished neighbors' experiences.

Contents

Using existing social infrastructure, CHVs were trained to perform a baseline census, conduct growth monitoring and promotion (GMP) sessions, perform positive-deviance studies, deworm children and supervise Nutritional Education and Rehabilitation Programs (NERPs) for seriously malnourished children. Information from the positive-deviance studies in turn guided NERP education, by identifying behaviors among poor families likely to explain their children's good nutrition, such as feeding them paddy shellfish and greens.

Evaluation of the program indicates the virtual elimination of severe and moderate malnutrition in the community. Authors concluded that local non-technical solutions "alleviated childhood malnutrition significantly, rapidly and sustainably amid settings of generalized poverty." They add that "while perhaps not a panacea, Positive Deviance is not a 'niche-tool' either. Resting squarely on equity, Positive Deviance not only targets those in need, but also requires guidance from them. Positive Deviance deserves wide usage."

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Internet: www.basics.org/Publications/HEARTH/hrth_ch5.htm

Private Providers: Practical Assessment and Intervention Tools for Improving the Treatment of Sick Children. Robert S. Northrup

Purpose

PRACTION (Private Providers Treatment Improvement Intervention) is an innovative approach to improving the care provided by private providers. It consists of two tools: *Verbal Case Review* (VCR) is an assessment method involving a delayed household exit interview of mothers who had brought a sick child to a provider within the past two weeks. Analysis of their responses produces a comparison of the diagnostic, treatment, and counseling actions of specific local providers with national or international IMCI guidelines. This tool is available as a questionnaire and reports on its use.

INFECTOM (Information, Feedback, Contracts, Ongoing Monitoring) is a four-component intervention method in which the implementing agency: provides *information* to providers on national case management standards; provides *feedback* to providers on their behaviors in comparison with those standards, based on the VCR baseline results; negotiates and *contracts* with providers to perform specific case management actions routinely; and conducts *ongoing monitoring* through VCRs carried out by community women's groups or health workers with feedback of the results to providers in relationship to their contracts.

Contents

This tool is available as a series of reports describing its application in various settings. Various implementers have used the tools in a variety of settings, targeting a variety of private providers: untrained and unlicensed village doctors; trained doctors, nurses, and midwives; and drug sellers. Interventions have used both group meetings of providers and visits to individual providers, clinics, or shops.

Results indicate significant improvement in private providers' case management practices. Some providers also began to participate in community health activities. In short, the methods are practical and can be effective in improving the quality of care by private providers for the most common childhood illnesses. Worthy of note is that in Pakistan, PRACTION was successful in reducing the frequency of injections and increasing the use of disposable syringes.

Ordering Information

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Health Sciences Education Center
255 Carter Hall Lane
Millwood, VA 22646
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XII.4 Selected Manuals on Participatory Research

1) Participatory Learning and Action: A Trainer's Guide
Jules N. Pretty, Irene Guijt, John Thompson, Ian Scoones. 1995.

Ordering Information

Pact Publications ($45, Item number IIE001)
777 United Nations Plaza
New York, NY 10017
Telephone: 1-212-697-9-6222
Fax: 1-212-692-9748
E-mail: books@pactpub.org
Internet: www.pactpub.com
ISBN 1 899 825 00 2

2) Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA): A Manual for CRS Field Workers and Partners
Karen Schoonmaker Freudenberger. 1999. Vol. 1: 104 pages; Vol.2: 105 pages.

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Baltimore, MD 21201-3443
Telephone: 1-410-625-2220 or 1-800-235-2772
Fax: 1-410-234-2994
Internet: www.catholicrelief.org

3) Institute of Development Studies PRA Methods and Topic Packs
Carolyn Jones and staff at the Institute for Development Studies, University of Sussex

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Heidi Atwood
Institute of Development Studies at the University of Brighton
Brighton BN1 9RE UK
Telephone: 44-1273-606261
Fax: 44-1273-621202
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